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PSYCHOLOGICAL TESTS IN PLANNING THERAPY GOALS

LELA A. LLORENS, O.T.R.*

Psychological test results can be a valuable aid in establishnig the indicated therapeutic attitude and in initiating occupational therapy goals coordinate wtih the fulfillment of the needs of the emotionally disturbed child. In a dynamic treatment situation, children admitted for therapy are given many examinations and many evaluations are sought. The psychologist is called upon to administer tests designed for evaluation of intellectual and emotional functioning. These examinations are one of the significant segments of the total evaluative process. Another aspect of evaluation is given by the occupational therapist. This unit calls for observation of the child relative to his behavior, performance, sociability and interests. No formal tests are given in this area but concrete formulations of the therapeutic attitude and treatment goals are necessary.

In order to give a complete picture of the scope of this paper, it is necessary to begin with a clarification of the emotionally disturbed child. For our purposes we speak of the child who is socially maladjusted. He has difficulty in his relationships to school, home and the community. Some of the maladjustments are severe, others appear mild by comparison. The four major diagnostic classifications under discussion are: the immature child (personality disorders); the neurotic child; the psychotic child; and the neurologically-impaired child (brain-injured).

THE IMMATURE CHILD

The immature child can be described as having an inability to handle excessive levels of tension. He has frequent temper outbursts which result from the failure to have his needs met immediately. His needs are usually manifested through demanding, selfish behavior, also by an exaggerated though frequently ambivalent display of independence and refusal of help. Frustration tolerance in this type of child is low and his reaction to frustration is aggressive and hostile in nature.

One child who demonstrated many of these symptoms in his behavior was nine-year-old Jimmy. He was extremely hyperactive with uncontrollable behavior characterized mainly by aggressive and assaultive outbursts directed toward members of his family and playmates. His temper outbursts, which were for the most part unpredictable, were persistently hostile. His demands for affection never appeared to be gratified. Jimmy had a strong need to consistently control the environment and the attitudes of the people around him.

Jimmy was seen by the psychologist and was given a full battery of tests. The results of his tests indicated that he was functioning in the middle of the average range of intelligence, and that he had difficulty maintaining control of his destructive impulses. He fluctuated between the need to act-out and inhibit these impulses. His hostility, noted in examination, was directed toward females in his environment. His most outstanding use of defense mechanisms appeared to be evasion, denial and undoing. There was fluctuation between mature and immature behavior. He appeared easy to like and seemed to have the capacity to alter his behavior when given a consistent environment.

The occupational therapy indicated for Jimmy (1) provided the opportunity to gratify some of his infantile needs, (2) provided a socially acceptable outlet for some of his destructive impulses through the use of aggressive activities, (3) recognized the need for and allowed the opportunity to be independent when need for this action was indicated, and (4) provided consist-

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Appreciation is extended to Eli Z. Rubin, M.D., coordinator of children's services, Lafayette Clinic, for his help in selecting the cases used in the text of this article.

ency in time and place for activity. The therapist's attitude focused around acceptance of hostile and aggressive behavior and expectation that the environment must furnish some ego control. A further implication in acceptance of Jimmy's hostility was that it was directed toward females in the environment.

Another child, who manifested symptoms of the type characterizing the immature child, was Donna. Donna, six years old, was also hyperactive with impulsive, demanding behavior. A temper outburst was her most frequent reaction when her demands were not satisfied immediately. At these times she screamed and used profanity. She was jealous of her siblings, aggressive to her peer group, rebellious toward authority and selfish. She withdrew from or evaded competition.

Because of Donna's uncooperativeness, she was only given one examination. Her score suggested that she had a functional potential of average intelligence. Her test behavior indicated a short attention span and low frustration tolerance. She would lose interest and want to terminate testing as items became difficult. The diagnostic impression was of an extremely fearful and distrustful child, who seemed overwhelmed with fear of strangers. She appeared to act out hostile impulses both directly and through negativism. Her ego controls were seriously impaired.

The occupational therapist's attitude for Donna focused around acceptance of hostile and aggressive behavior. The plan included (1) activities through which she could receive gratification within a short time, (2) activities geared well within her potential, thus relieving possible frustration, and (3) opportunities for gratification of her need for love and affection.

These were necessarily initial treatment goals on which to form a working relationship. Other more specific treatment goals supplemented these as treatment progressed.

THE NEUROTIC CHILD

The neurotic child is hyperactive, restless, fearful, clinging and self-condemning. His hyperactivity and restlessness stem from the anxiety produced by a conflict between the need to express emotion and the need to inhibit this expression. He is fearful of people and their attitudes toward him. At the same time, these children seek condemning, punishing attitudes through their clinging, crying and acting-out behavior.

Douglas, nine years old, was an example of the neurotic child. He had difficulty getting along with his peers. He either isolated himself from them or became aggressive and destructive toward them. He was jealous, demanding, impulsive and hyperactive in behavior; he had developed fears of the dark and of being hurt; he had a short attention span and low frustration tolerance.

Douglas was seen for psychological testing and received a full battery of tests. His performance during testing indicated a superior potential intellectually with present functioning at average to bright average levels. His reaction to stress situations markedly interfered with his performance on occasions. Douglas displayed considerable creative ability and originality. He would have liked to be aggressive and assertive but this seemed to connote sexual transgression and carried with it a threat of annihilation.

Douglas' resources for solving his conflicts included intelligence, a rich, fantasy life into which he could retreat for gratification of his impulses without complete loss of control, a real capacity for insight and the strength to oppose a threatening environment. A firm, well established environment was indicated with the opportunity to identify with consistent accepting adults who set limits he could rely on.

The occupational therapist's attitude for Douglas employed warmth, acceptance and an expectation that the environment set limits for ego control. The initial treatment goals provided (1) the opportunity for impulse release through original, creative activities, (2) the opportunity for independence without rejection and with the needed emotional support, (3) an acceptable emotional outlet through aggressive activities, and (4) a secure segment of the total environment.

Another child who demonstrated neurotic symptoms was Stephen, twelve years old. He showed disruptive, explosive, acting-out behavior; he refused to cooperate and resisted all efforts in this direction.

In psychological testing, Stephen was given a full battery of tests. His intellectual functioning was bright-normal with a probable potential of superior to very superior. In the test situation, Stephen was extremely responsive to praise and encouragement, sensitive to environmental stimulation and equally vulnerable to criticism. He tended to be uninterested in prosaic details and to focus on more lofty, ambitious conceptions. When anxieties were acute, impulses tended to break through and interfere with his capacity to organize test material in a logical manner.

His ego appeared mature and well-developed in some areas. He had well internalized controls, the ability to enter empathetically into interpersonal relationships, and was able to utilize various defenses against anxiety. His super-ego was well developed but its relative severity played an important role in intensifying Stephen's anxieties. He was struggling with hostile impulses which he could not express because he feared loss of love

and evidenced super-ego anxiety. Stephen had feelings of unworthiness and low self-esteem and was particularly sensitive to criticism and rejection from object relationships. Warmth, understanding, recognition and considerable reassurance were important in any therapeutic relationship with Stephen.

The occupational therapist's attitude for Stephen employed warmth, acceptance and understanding. His treatment plan provided (1) recognition and raising his self-esteem, and (2) opportunity to act independently without loss of love. The fact that he was responsive to praise and encouragement coupled with his high intellectual functioning were valuable assets in fulfilling these needs in the occupational therapy area.

THE PSYCHOTIC CHILD

The psychotic child often demonstrates autistic features in his personality. He may be a withdrawn and unresponsive individual who has extreme difficulty forming relationships with people in the environment. Withdrawal with these children is a learned reaction to frustration from the environment. These children have difficulty in distinguishing themselves from their environment and may have fears concerning separation from objects in the environment. It is altogether possible that an autistic child may be mistaken as feeble-minded because of his markedly retarded ego development. We may also see loss of contact with reality and delusional and hallucinatory trends.

Two children who showed many of these symptoms were Christine and Ricky. Christine, a six-year-old girl, had shown a fear of strangers from the age of three. She screamed and withdrew from them in most instances. At other times, she exhibited much uncontrolled acting-out behavior such as swearing, throwing objects and name-calling. When approached she frequently asked to be let alone.

Christine was seen for psychological evaluation and received a full battery of tests. On projective test responses, Christine showed almost complete indifference to the demands of reality. She showed clear evidence of autistic and perseverative thinking where her initial responses were triggered by inner needs. Interspersed with autistic behavior were periods when Christine was able to show appropriate, reality-oriented responsiveness. At these times her level of anxiety was markedly elevated and was evidenced by verbal confusion.

The occupational therapist's attitude toward Christine incorporated warmth, affection and consistency. Her initial goals provided (1) an opportunity to experience gratification through the use of concrete, structured, reality-oriented activities, and (2) an undemanding, fear-reducing atmosphere.

Ricky, eight years old, seemed to live in a dream world about which he related fantastic stories. He had no sense of responsibility and was demanding and affection-seeking. He resorted to measures of intimidation when demands were not immediately met.

Ricky was tested with a full battery of psychological tests. His level of intellectual functioning was rated high-average with indications of bright-normal to superior potential. During testing Ricky showed frequent loss of reality contact. He seemed preoccupied with threatening, devouring creatures which he would defend against with magical devices. He showed a capacity to relate at a primitive level and appeared to be a schizophrenic child whose potential for improvement depended on consistent, firm, non-stimulating handling with an emphasis on reality structuring.

The occupational therapist's attitude for Ricky incorporated warmth, affection and consistency. His treatment goals, like Christine's, provided (1) the opportunity for impulse release as well as gratification of his needs through the channelization of his fantasy material into reality-oriented activity, and (2) firm, consistent limits for ego control.

THE NEUROLOGICALLY-IMPAIRED CHILD

Children who are classified as neurologically impaired have organic brain disfunction which results in behavior disorders. These children are impulsive and tend to display severe temper reactions toward frustration. These children also show an inability to learn by experience and to associate cause and effect. The neurologically-impaired child is easily distracted by environmental stimuli. He also shows signs of regression, marked anxiety and fear of failure.

James, a nine-year-old boy, was neurologically impaired. He had more difficulty learning in school than other children his age. He tired easily and had difficulty running. His memory was poor and he had difficulty understanding instructions. When playing with other children, James usually preferred a child younger than himself.

In psychological testing James was given the full battery of tests. His intellectual functioning was found to be borderline; his potential was at least average. James retained intact areas of ego development and appeared to have potential for control. He had some capacity for identification through interpersonal relationships and used certain compulsive defenses at times. James' main conflict focused on his needs for affection and security. Deprivation of these resulted in marked hostility. James saw himself as helpless and in-

adequate, and defended against this by a superficial facade of protesting aggressiveness. There were some tendencies toward feminine identification. James needed a secure, consistent environment and warmth, affection and support from object relationships.

In addition to a warm, accepting attitude on the part of the occupational therapist, a non-pressuring, non-stimulating one was indicated for this child. The goals for James provided (1) an opportunity to perform in an atmosphere that was relaxed in its performance expectancy, allowing him to work to his fullest potential, (2) expression of affection when indicated and allowance for him to express affection, however strained and forced, without rejection or retaliation, and (3) the opportunity for accomplishment at his own level to build a feeling of adequacy and worth.

Another child whose symptoms placed him in this classification was Bill, who did not gain satisfaction from playing with other children. He had severe temper tantrums when faced with frustration. There was sexual confusion in this case along with other problems of orientation to the environment.

Bill received psychological testing. His intellectual functioning was dull-normal and he showed an inability to abstract adequately. He also displayed considerable immaturity and disorganization. His frustration tolerance was very poor he performed typically in an impulsive, slap-dash manner. He made little effort to stay with a task or attempt to improve performance. Emotional stimulation was difficult for Bill to handle. He was preoccupied with security needs, fearing annihilation and bodily injury. He was searching for strong figures with whom to identify.

Here again the need for a warm, accepting attitude on the part of the occupational therapist was indicated. Behavior may not be as much of a problem with the neurologically-damaged child as with the immature or neurotic child; however, the attitude of acceptance is needed in the area of intellectual functioning.

The treatment goals indicated for Bill provided (1) opportunity to receive some measure of gratification through the use of short-term activities with low frustration threshold and (2) a consistent and secure segment of the total environment.

CONCLUSION

It is important to bear in mind the fact that the occupational therapy goals as stated here were established early in treatment and were subsequently changed during the course of therapy depending on the behavior of the child, the relationship to the therapist and the overall therapeutic goals prescribed by the psychiatrist. It must also be remembered that there are many other ways of arriving at occupational therapy attitudes and goals. This paper presents only one method. The value of this method lies in the acceptance of psychological test results as diagnostically significant.

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Calendar of Events

October 13-15, 1960

Mississippi Valley Conference on Tuberculosis, Schroeder Hotel, Milwaukee, Wisconsin.

October 31-November 4, 1960

The annual meeting of the American Public Health Association, San Francisco, California.

October 31-November 2, 1960

Annual conference on electrical techniques in medicine and biology, Sheraton-Park Hotel, Washington, D. C.

November 13-17, 1960

Conference of the American Occupational Therapy Association, Statler Hilton Hotel, Los Angeles, California.

June 4-10, 1961

The third world congress on psychiatry, Montreal, Canada.

August 30-September 5, 1961

Sixth international congress on mental health, Sorbonne, Paris, France, under auspices of the World Federation for Mental Health.

ADMINISTRATIVE PLANNING OF PATIENT ACTIVITY PROGRAMS IN MENTAL HOSPITALS

JOAN M. DONIGER, O.T.R.*
H. DWYER DUNDON, O.T.R.†

Formal hospital administration has a profound influence on the kind of activities program that can be offered to patients in mental hospitals. Some of the current administrative practices sometimes prevent the best possible use, from the point of view of the patient, of the various kinds of activity programs now available. Some of the kinds of activity programs in mental hospitals currently are: occupational therapy, recreational therapy, art therapy, music therapy, bibliotherapy and dance therapy.

With the introduction of many new therapies into the mental hospital setting, there has been, understandably enough, confusion and difference of opinion about how services performed by these therapists and their staffs might best be employed. In some institutions, there has been a random "Topsy-like" growth. Each time a hospital became aware of and interested in the possible contributions of a new kind of activity as therapy, a new department or sub-service was set up in a different section of its organization or physical plant in order to include the new activity. Other hospitals have made broad groupings according to the academic specialization of the therapists, like occupational therapist, music therapist or recreational therapist. Many possible combinations and separations of the various therapies exist and it is possible to find examples of a wide range of them in hospitals today.

The results of such piecemeal, rather than overall, planning have not always been completely satisfactory. From the administrative point of view there is often insufficient activities personnel to meet existing needs, a situation made more difficult by inefficient utilization of the existing personnel arising from overlapping functions in some areas and inadequate coverage in others, and also from faulty communication among the various types of therapists. Because of these conditions, hard working and conscientious activity workers have met with frustration and hostility from competing groups, the members of which also have been doing their best.

Because of such conditions patients have not always benefited from the program as much as they might. The lack of coordination and the very multiplicity of activity therapies results at best in a fragmented life for patients — a life in which the hour assigned for one type of supposedly therapeutic activity bears very little integral relationship to the other hours assigned elsewhere. At worst, however, patients may be lost in the confusion, and may receive little or no systematic attention within the activity program.

These observations have repeatedly been made by persons who have seen, and tried to cope with, the growing problems of a proliferating group of activity professions. Among the most noteworthy trends during recent years, reflecting such observations, have been the coordination within some hospital systems of all activity therapists into one department.

The Menninger Foundation has named such a department adjunctive therapies. The Veterans Administration unified these same functions within their department of physical medicine. Others have called such division ancillary therapies, collateral therapies, or rehabilitation departments. These have all represented steps toward a recognition that the various therapists have common goals which can be more effectively met by working together. Despite such steps, however, rivalry among therapists having different specialties and identification with different national organizations continues. In fact, it seems as if wrangling over the prerogatives of each therapist's particular group is increasing as more varieties are established and each seek to attain professional recognition.

It is possible that a more rational—and more radical—reorganization might alleviate the problem. Instead of reviewing how activity therapy is now provided and suggesting a change here and there, this paper has tried to make a fresh start and to design a plan which should function optimally.

One should begin the consideration of such a plan by thinking about *patient needs,* and about what a hospital activity program should contribute to them. Considering the mentally ill in general rather than any particular classification of patients, the one criterion for an activity program is the need for as many features of normal living as the patients are capable of. It is obvious that, in varying degrees, patients are not able to adjust to all aspects of life outside an institution. This does not, however, preclude their need for many of the aspects of normal living. Some of these needs

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are for self-expression, for belonging, for giving, and for recognition. Healthy people recognize and have opportunities for filling these needs through work, recreation and companionship with others. Some patients also recognize some of these needs, but the opportunities to satisfy them are limited by the institutional setting. For those whose illness prevents them from seeking such fulfillment, the activity program should provide stimuli and guidance toward such a search. In brief, the activities which maintain and preserve mental health for the healthy may, when properly provided, help restore it for the mentally ill.

It should be noted that many psychiatrists, sociologists, and anthropologists who have studied the structure of the mental hospital have reported the incongruities that it has historically permitted. Jules Henry, in particular, has presented stimulating material in two articles on this subject.[1] Another approach to this same problem can be found in a discussion called "A New Perspective on Training and Practice in Occupational Therapy," by Beverly J. Granger.[2]

A PLAN FOR ACTIVITY THERAPIES

Any ideal plan for the rational administration of activity therapies is, of course, most appropriate for hospitals which have underdeveloped activities departments, or for hospitals undergoing extensive reorganization. Under the clinical director of the hospital such a plan would include a director of patient activities supervising three principal divisions. These may be designated as: (1) the unit programmer, (2) the skill specialist, (3) the work specialist.

The unit programmer. If one of the basic goals of activity in hospitals is the provision of a full and "normal" day of work, learning and recreation as each patient can achieve, then it follows that the job of an activity program should start with the patients where they are — that is in the wards and with ward personnel. A strategic position in this organization would be that of the unit programmer. He would enter the daily life of the ward, familiarize himself with their group and individual needs, observe their relationships with each other and with other staff members, and become aware of and attempt to fill the significant gaps in hospital routine which activity programs should fill.

It is upon him that ultimate reliance could be placed for not overlooking or "losing" any patient. The patients' day would be planned as a whole. It is the unit programmer who would maintain daily contact with the rest of the medical staff and reduce the isolation of the activity therapists often found in present day hospitals. To this end he would regularly consult with and teach skills to ward personnel. He would encourage their regular participation in activities and generally act as a resource person to ward personnel.

Among the tasks of the unit programmer would also be such considerations as the number of patients to be served in relation to the number of activity personnel available. It would also be his responsibility to help direct the division of patients between the second part (skill specialist) of the program and the third part (work specialist). The over-all needs of the hospital and, in particular, of each individual patient should fall within the purview of the unit programmer.

The skill specialist. The second group of activities personnel would be the skill specialists. This group would plan activities which might cut across geographical boundaries, such as buildings or wards. The particular kinds of activities that this group would offer would depend, of course, on the therapeutic needs of the particular patient group. Traditionally used have been the crafts, music and sports. However, skill specialists might even include those able to offer classes in typing, soil conservation, animal husbandry, or study of the great books, should these seem appropriate. When indicated, skill specialists would go with the unit programmer to the various wards or buildings to carry on their activities there. Included among the skill specialists' functions would also be consultations when necessary to help integrate their work in the general therapeutic program.

The work specialist. The work specialist is also, in a sense, a skill specialist, but his activities are those that are generally viewed as less educational. His goals are of course also therapeutic, but have different mainsprings and directions, since in this part of the program there is more emphasis on productive work. Here the patient finds the opportunity to contribute something to the community that he belongs to, and thereby becomes a more important part of it. In addition to the previously mentioned acquiring of skills, he may get the opportunity to discover or test out his own personal resources. The work specialist, too, may work either on wards with the unit programmer, or in a geographically central place. From the point of view of the professions involved, a therapist would be assigned to one of the three above mentioned groups within which he could function most effectively. This might be determined more by his interests and talents than by his training. For example, an occupational therapist or recreational therapist who was very versatile could be a unit programmer. However, those more interested in the specific use of crafts or sports as a therapeutic activity would be skill specialists.

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INTENSIVE THERAPY FOR CHRONIC MENTAL PATIENTS BY UNTRAINED PERSONNEL*

EILEEN DIXEY, O.T.R.
GEORGE M. HASLERUD, Ph.D.
G. DONALD NISWANDER, M.D.
EDWARD RUTLEDGE

In two earlier studies relating to the role of the occupational therapist, first with the chronically mentally ill,[1] and later with acute newly admitted mental patients,[2] the therapist's role differed according to the spontaneity of the groups. The chronic group of patients required much personal attention and encouragement to promote activity. The newly admitted group needed less encouragement, but required more routine service, such as help in selecting supplies or guidance in new techniques. In both groups the activity of the therapist greatly increased the amount of social interplay among the patients. Both studies suggested that untrained persons in a hospital setting with adequate supervision might likewise increase patient social activity. Further, the services of untrained individuals would allow a wider spread of desirable activity despite an inadequate supply of trained therapists.

Consequently a research project was instituted to test the value of untrained but closely supervised persons working intensively with chronically ill mental patients.

PROCEDURE

An intensive 38-hour treatment program was planned allowing time for personal hygiene, ward housekeeping, and occupational, recreational and industrial therapies.

Only schizophrenic patients were selected to participate in the project. After excluding those who were either organically defective, physically ill, or participating in any other activity program, 16 male and 16 female patients were chosen by means of a table of random numbers. These patients were divided into two groups: an experimental group and a control group, the former having a mean age of 55.8 years and a mean length of hospitalization of 22.6 years; the latter a mean age of 50.9 years and a mean duration of hospitalization of 16.1 years.

Both groups continued to live in the same ward areas. The control group had only the usual ward program routines, such as occasional walks on the hospital grounds and weekly dances and baseball games. The experimental group was subjected to the special intensive OT, RT, and IT treatment program, as shown in Figure 1.

The experimental group was subdivided into two male and two female groups, each group including only patients from the same ward. Therefore, each experimental group consisted of four patients under the guidance of an inexperienced psychiatric aide.

Four men and four women college students, working as temporary psychiatric aides, were selected from a group of 28 students. Over-and under-enthusiastic individuals were eliminated by their group counselor, and the eight were selected from the remaining group by means of a table of random numbers. Each of the four students had charge of a group of patients during the first month of the experiment; the other four students replaced them during the final month. The students received a pre-project orientation on the ward for one week prior to taking their assignment.

Three means were used to evaluate the progress of the patients in the study; clinical interviews, ratings of social behavior, and anecdotal diary material of the student aides.

Both experimental and control groups were interviewed clinically by one staff psychiatrist before, at the mid-point, at the conclusion of the study, and as a follow-up procedure bi-weekly for six weeks. This psychiatrist rated each patient at each interview without knowledge at hand of his previous ratings and without knowing which patients belonged in the experimental group.

Socialization ratings were made in the OT clinic by a graduate psychology student. Using a scale similar to one proven reliable in a previous study,[3] three 20-second ratings were made during each clinic session.

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*From the Arthur P. Noyes Institute of Neuropsychiatric Research, New Hampshire State Hospital, Concord, New Hampshire.

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WEEK OF	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
A.M. 7 - 8:30	WARD LIVING	WARD LIVING	WARD LIVING	WARD LIVING	WARD LIVING	AS WEDNESDAY
A.M. 8:30 - 11	OFF WARD JOB GR. 1-KITCHEN GR. 2-GROUNDS DEPT. GR. 3-MENDING UNIT GR. 4-KITCHEN	OFF WARD JOB GR. 1-GROUNDS DEPT. GR. 2-KITCHEN GR. 3-KITCHEN GR. 4-MENDING UNIT	8:30 - 9 REST PERIOD 9 - 11 COMBINED GROUPS RECREATION	OFF WARD JOB GR. 1-KITCHEN GR. 2-GROUNDS DEPT. GR. 3-MENDING UNIT GR. 4-KITCHEN	OFF WARD GR. 1-GROUNDS DEPT. GR. 2-KITCHEN GR. 3-KITCHEN GR. 4-MENDING UNIT	
P.M. 1 - 2	GR. 1-OUTDOOR REC. GR. 2-ARTS & CRAFTS GR. 3-LIBRARY GR. 4-ARTS & CRAFTS	GR. 1-ARTS & CRAFTS GR. 2-LIBRARY GR. 3-ARTS & CRAFTS GR. 4-OUTDOOR REC.	VISITING DAY	GR. 1-LIBRARY GR. 2-ARTS & CRAFTS GR. 3-OUTDOOR REC. GR. 4-ARTS & CRAFTS	GR. 1-ARTS & CRAFTS GR. 2-OUTDOOR REC. GR. 3-ARTS & CRAFTS GR. 4-LIBRARY	
P.M. 2 - 2:30	REST PERIOD GR. 3 TO CANTEEN	REST PERIOD GR. 2 TO CANTEEN		REST PERIOD GR. 1 TO CANTEEN	REST PERIOD GR. 4 TO CANTEEN	
P.M. 2:30 - 3:30	COMBINED GROUPS RECREATION	COMBINED GROUPS RECREATION		COMBINED GROUPS RECREATION	COMBINED GROUPS RECREATION	
P.M. 6 - 8	EVENING DANCE			EVENING BASEBALL GAME		

Figure 1. *Activity Schedule for Experimental Group*

SOCIALIZATION SCALE

1. Negative interaction, verbal or non-verbal aggression against patient(s) or therapist(s). Withdrawal from the social advances of others when presented.
2. Absence of socialization.
3. Non-verbal socialization with therapist(s).
4. Non-verbal socialization with another patient(s)—a passive involvement with the activities of others.
5. Verbal socialization with the therapist(s).
6. Verbal socialization with another patient(s).

Sociograms were drawn in between time samplings of socialization. From the sociograms patients were rated individually, utilizing the following scale.

SOCIOGRAM SCALE

1. Withdrawal.
2. Refusal to interact
3. Wandering
4. Looking at things
5. Looking at people
6. Interacting with therapist(s) or student(s)
7. Interacting with other patient(s)

Each student kept a daily record of observations relating to the individual and group behavior of all patients under his care. This anecdotal material was analyzed in terms of affirmative and negative statements concerning verbalization and concrete social behavior observed in each patient.

All three kinds of data were analyzed by nonparametric methods. The six clinical interviews for each patient were examined in pairs, the last of each pair rated plus for improved, zero for unchanged, and minus for worsened. This was done by four psychiatrists rating independently. A later blind re-rating was used as a reliability check. For socialized behavior, the scales used gave relative measures suitable for nonparametric statistics without further processing. For the anecdotal material, each statement indicating any degree of social activity was tabulated and given the sign of plus or minus: e.g., "Patient refused to leave ward for recreation hour," minus; "Patient helped tidy up kitchen after coffee break," plus. Cumulative curves were made by algebraic summations for the anecdotal materials and the interviews.

RESULTS

The reliability of the psychiatrist's ratings of the clinical interviews proved adequate. The general agreement was that the patients in the experimental groups improved during the eight weeks of the project, and then regressed during the following six weeks. A similar effect, but to a much lesser degree, was also noted in the control groups, as shown in Figure 2.

In both social behavior ratings and sociograms, as shown in Figures 3 and 4, there was a general improvement during the eight-week period that was, however, significant only during the last four weeks. An unexplained regression in the sociograms of the seventh week was, however, followed by a return to the improved level during the eighth week.

Figure 5, the cumulative socialization statements for anecdotal material, showed a widening gap between "minus" and "plus" curves which reached significance in the later weeks of the project. The positive observations increased at a more rapid rate than the negative as the project progressed.

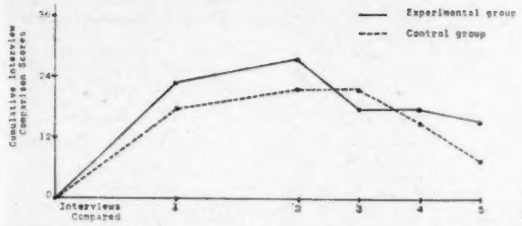

Figure 2. Comparison of experimental and control group psychiatric evaluation. (Scores are summated for each group and plotted accumulatively.)

DISCUSSION

While the results of this study seem to demonstrate that closely supervised untrained personnel can work with chronically ill mental patients and increase their social activity, there are still some aspects of the data which require further interpretation. The improvement of the control group as measured by clinical interview evaluations showed a remarkable similarity to that of the experimental group (Figure 2). Moreover, the socialization scores (Figure 4) and the sociogram scores (Figure 3) did not correlate from week to week as one might expect. In fact, the sociogram scores do not seem to be consistent with themselves. The meaning of these relationships needs exploration and clarification.

Figure 2 may be sensibly interpreted by treating the control and experimental groups separately. The experimental group showed a dramatic improvement during the first half of the intensive treatment program, followed by a moderate improvement in the second half of the program. This was to be expected, since the subjects had been in a socially impoverished environment before they were suddenly given eight hours a day of intensive treatment. This new environment stayed essentially the same for the eight weeks of the study. Thus the greatest improvement corresponded to the most dramatic change in the

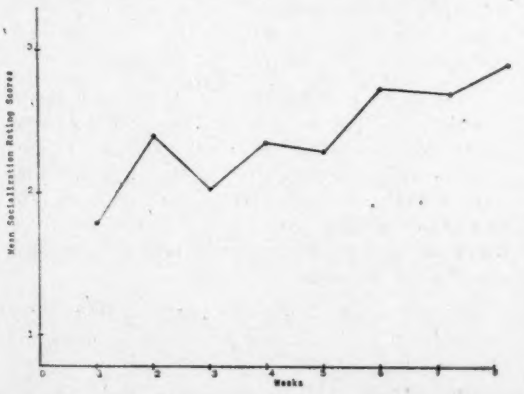

Figure 3. Socialization of experimental group patients during the period of intensive treatment as measured by socialization rating scores.

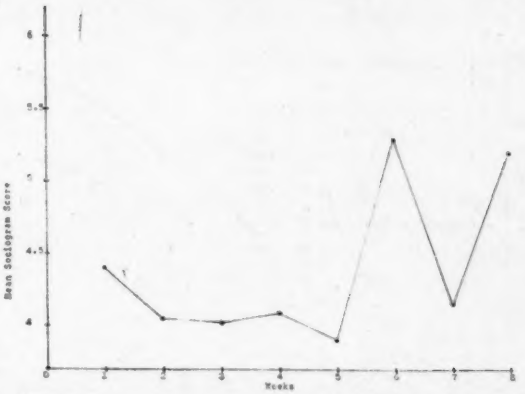

Figure 4. Mean socialization of experimental group patients during the intensive treatment period as measured by sociogram scores.

environment. The same trend was noted in a previous study[1] in which chronic patients, naive to occupational therapy activities, were changed from an environment in which the therapist was merely passive to one in which he was fully active as a therapist.

At the end of the intensive treatment period there was a sharp decline (Figure 2), probably due to the sudden return to the old impoverished environment. This was followed by a leveling off which shows that the experimental patients held a considerable part of their improvement for at least six weeks.

The curve indicating changes in the clinical picture of the control group has almost a symmetrical rise and fall. This may be a result of the evaluation interview itself. Even though no therapy was attempted during the interviews, the mere attention of a psychiatrist might well have aroused interest and built up the patients' expectations in such an impoverished environment. In Gestalt terms, the figure-ground contrast must have been great. Since each interview followed the same protocol, the patients may have become indifferent as the interviews progressed.

The inconsistency between Figure 3 and Figure 4 combined with the wide fluctuations in Figure 3 seem to indicate that the sociograms constitute a tenuous measure of social behavior. The socialization scores (Figure 4) showed a consistent pattern of improvement with only slight random fluctuations. The sociogram scores, on the other hand, showed a regression from weeks one to five. Further there was a dramatic rise between weeks five and six and a low point at week seven. The latter might be explained by a minor disturbance that occurred one day in the occupational therapy clinic when both observers became involved in the clinical situation. Since all evaluative instruments except the sociograms showed a

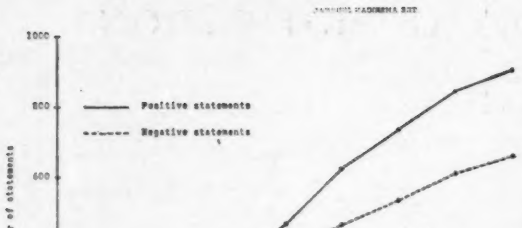

Figure 5. Comparison of positive and negative social behavior of experimental group patients during intensive treatment, as determined by anecdotal statements of the temporary psychiatric aides.

steady overall improvement of the experimental group during the study, we therefore question the validity of the sociogram scores. Further, the cumulative curves (Figure 5) of the "plus" and "minus" anecdotal material bear out that improvement was progressive during the active part of the study.

From this data the authors again conclude that there is a need in large mental hospitals for more programs of the type used in this experiment. In this study the social behavior of the patients improved more than their clinical picture. This improvement stopped, declined, and leveled off after the active program ended. This suggests that permanent gains for chronic mental patients might be realized from a continuous, even though less intensive, program. Moreover, this experiment demonstrates that the attention of untrained psychiatric aides can have therapeutic value to chronic mental patients. In large mental hospitals the utilization of trained occupational therapists as supervisors for such untrained individuals could greatly expand the therapeutic social environment.

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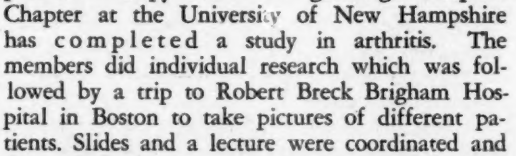
HONOR SOCIETY FOR OCCUPATIONAL THERAPY STUDENTS

Pi Theta Epsilon, the honor society for occupational therapy students is growing. Alpha Chapter at the University of New Hampshire has completed a study in arthritis. The members did individual research which was followed by a trip to Robert Breck Brigham Hospital in Boston to take pictures of different patients. Slides and a lecture were coordinated and donated to the department to be used as visual



Money making project, Alpha chapter. Left to right: Pat Turnball, membership chairman; Fay Barrnet, president; Virginia Bell, advisor; Carolyn Musser, secretary-treasurer, a customer.

lecture aids. To increase the financial resources, the members had a daily coffee and doughnut sale in the arts building. Next year they hope to put further efforts into expansion and unification of Pi Theta Epsilon nationally.

Beta Chapter at Colorado State University has been making bibliography cards for past issues of AJOT. They too have capitalized on the food business to increase their treasury by selling cokes at an annual stunt night.

At Western Michigan University, Gamma Chapter played hostess at the department's dad's day open house and at a meeting of affiliation directors. This group has also sponsored a show case in a student center. Last spring they conducted an activity program at a nursing home, working in cooperation with Michigan State committee on the problems of aging. In the future they hope to have a meeting with freshmen to encourage them toward Pi Theta Epsilon eligibility.

Delta Chapter at Texas Woman's University has concentrated on organization. Their first initiation was January 29th, and was followed by another on May 12th. They hope to bring more members in with the fall semester.

(*Continued on page 261*)

AN EXPERIMENTAL STUDY OF MOTIVATION *

HARRY L. MADISON, Ph.D.†
MARJORIE B. HERRING, O.T.R.‡

Often patients forget how seriously they were handicapped at the beginning of therapy, and this may contribute to loss of motivation in long term rehabilitation. To investigate the potential motivating value of providing the patient with a graphic, easily visualized record of his progress, we conducted a formal experiment in occupational therapy. First, we selected a battery of motor skills tests involving use of the hands, and administered them to normal subjects to see how the tests correlated with one another and to gain practice in their uniform administration. Then, these tests were given to two groups of patients with impaired use of a hand. The control group was tested at the beginning and end of a 30-day period. The experimental group was similarly tested but, in addition, was tested twice during the intervening time with a device which provides accurate, easily visualized recordings of finger movements. It was hoped that these graphic indications of improvement would provide additional motivation for the experimental group and somehow contribute to faster progress. Of particular interest would be greater improvement on tests which involve movements and skills other than those used in the finger movements which were recorded, since this would suggest that something other than mere practice was a factor, presumably motivation.

RECORDING APPARATUS

In 1957 we began development of a device for recording movements of the metacarpophalangeal joints of patients with impaired use of the hands. This device, shown in Figure 1, constrains the patient's hand, permits arcing movements of the four fingers in unison, and provides an electrical signal for precise recording of the movements. It consists of a wood base with an adjustable Masonite panel moving forward and backward on top which may be locked in one of several positions according to the patient's hand size. Attached to the end of the panel is an aluminum strip with grooves to accept two vertical posts with U-shaped brackets at the upper end. One of these, depending upon the hand being tested, can be adjusted to support and hold the thumb in an inactive position.

Two aluminum arms are attached rigidly to the base, extended six inches with holes drilled to accept a ball-bearing for a one-fourth inch shaft. Spanning the two arms is a light-weight aluminum bridge which supports a thin aluminum sheet with a one inch longitudinal adjustment. The patient's fingers are secured to the sheet, under

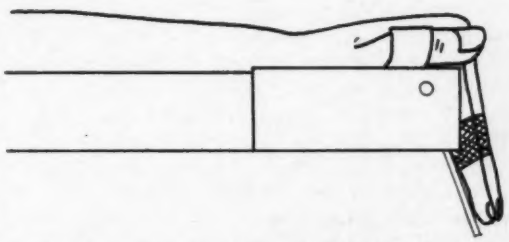


Figure 1. A representation of the device for recording finger movements.

a contoured plexiglass plate, by adjustable canvas straps. When the fingers are properly secured, the arcing of the fingers comfortably follows the arc of the bridge and turns the shaft of a precision potentiometer. This provides the signal which is recorded on a single channel of a Grass Model 5 Polygraph capable of following the most rapid finger movements. A typical recording is shown

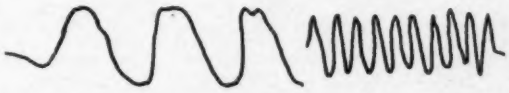


Figure 2. Typical records of finger movement.

in Figure 2. On the left is indicated the complete range of movement from maximum extension, upward on the record, to maximum flexion, downward on the record. On the right is shown a recording of rapid, smaller movements obtained when the patient is instructed to move his fingers as rapidly as possible in a comfortable range. The device is easily adapted to record wrist movements, also.

TESTS OF NORMAL SUBJECTS

Five motor skills tests, along with tests using the device for recording finger movements, were given to 18 normal subjects drawn from an introductory psychology class. Tests were given under conditions closely approximating those which would prevail when patients were tested. The tests, administered in random order, were:

(1) *Pursuit rotor.*[1] This is perhaps the most common test of perceptual-motor skill used in ex-

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perimental psychology. It requires the subject to hold the tip of a flexible stylus on a small, moving spot. In the form of the apparatus used here, contact with the spot starts it moving circularly on a phonograph turntable which can reach a speed of 70 revolutions per minute. Total time on target in hundredths of a second during one minute is recorded. The test requires coordinated use of eye and hand, and is rather difficult.

(2) *Minnesota Rate of Manipulation Test.* This common test of motor skill consists of 60 cylindrical blocks, about one and one-half inches in diameter, colored red on one end and yellow on the other, seated in cylindrical holes on a board. The subject is required to turn over each block in its hole. Total time for the performance is recorded. The test is an indication of coordination of arm and hand use.

(3) *Hi-Q Test.* This test utilizes a peg-board, originally sold as a toy, with pegs about one-half inch in diameter. There are two boards with the same number of holes and one board is fitted with the pegs. The subject's task is to pick up each peg individually and insert it in the same relative position in the other board. Total time for the task is recorded. This test has a larger dexterity component than does the Minnesota test.

(4) *Tweezer Dexterity Test.* This test consists of a circular array about six inches in diameter, of 40 small holes, with a nail inserted in each hole. The subject's task is to use tweezers to grasp each nail, remove it from its hole and deposit it in a centered container. Total time for the task is recorded. This is a relative gauge of speed in the reciprocal action of the fine finger muscles.

(5) *Sponge Test.* This original test consists of two metal cans, about six inches in diameter by eight inches high, one containing a number of one-half inch cubes cut from sponge rubber. The subject's task is to grasp as many sponges as possible with one hand and transfer them to the other container. After two practice trials in which the sponges are grasped but not transferred, the number of sponges transferred to the second container in one trial is recorded. This is a relative gauge of strength and range of motion.

With the device for recording finger movements, one static and two dynamic measures are obtained:

(1) *Range.* With the fingers constrained to move in a vertical arc, a complete range of movement is recorded, from maximum extension to maximum flexion.

(2) *Speed.* The subject is instructed to move his finger as rapidly as possible in an arc of comfortable range. The total number of sweeps or excursions in four seconds is determined.

(3) *Distance.* From the same record used for the speed measure, the total curvilinear distance in four seconds is determined.

	Minn.	Hi-Q	Tweezer	Sponge	Range	Speed	Dist.
Pursuit	—.26 —.20	—.34 —.07	**—.62** .13	.12 .15	.00 —.41	.08 .04	**—.64** .02
Minn.		**.56** **.65**	**.97** —.01	.11 —.04	**.90** —.21	—.32 —.34	.25 —.02
Hi-Q			.45 .43	**—.49** **.47**	**.48** .00	**—.65** .03	.06 —.02
Tweezer				—.20 .26	.18 —.17	—.33 .26	.00 —.01
Sponge					.11 —.17	.04 —.01	—.08 —.38
Range						—.01 .28	.12 .26
Speed							.18 .08

Inter-test product-moment correlations for normal subjects. Underlined coefficients are significant at the .05 level of confidence for 16 d.f.

Table 1

Table 1 gives the product-moment correlation among test scores for normal subjects. The upper numbers are for the dominant hand, the lower ones for the non-dominant hand. The underlined correlation coefficients are statistically significant at the .05 level of confidence for 16 degrees of freedom, i.e., the odds are less than 1 in 20 that such a high correlation could be obtained merely by chance for the number of subjects tested. Tests which correlate significantly with one another may be assumed to measure the same skills to some extent. These results suggest that the skills involved in these tests are not all so closely related to finger movements that we should expect mere practice in finger movements automatically to improve all the other test performances.

THE EXPERIMENTAL STUDY

For our experimental study of the possible effects of enhanced motivation on recovery of function, the occupational therapy facilities, and 34 patients, of the Curative Workshop of Milwaukee were made available to us. The patients were divided into two matched groups of 17 and one group selected at random as the experimental group. Patients are usually referred to the Curative Workshop by private physicians and may withdraw from therapy without advance notice. Of the 34 who began the experiment, only 16 completed it, 11 in the experimental group and 5 in the control group.

The experiment lasted for one month and was divided into three phases. During the first week, all patients were tested with the five motor tests previously described and with the device for recording finger movements. During each of the next two weeks, patients in the experimental group were tested once with the the finger-movement devise. The control group was not tested. In the last week, all patients were re-tested, just

as in the first week. The order in which tests were given was randomized for all patients.

The experimental and control groups were compared as to improvement in performance on each test. Table 2 shows the value of a "t" for independent measures calculated for each test. A positive value indicates greater improvement for the experimental group in use of the impaired hand.

Test	t
Pursuit Rotor	.39
Minn. Rate	.47
Hi-Q	.40
Tweezer	.19
Sponge	.11
Range	1.17
Speed	1.37
Distance	1.16

Results of comparison of improvement between experimental and control groups. Test statistics is "t" for independent measures.

Table 2

None of these statistics are significant, however, and we cannot confidently dismiss the possibility that the results are a matter of chance. They are all in the direction supporting our experimental hypothesis so that the results are encouraging but by no means conclusive. Assuming that the differences in improvement between the two groups are genuine, this outcome may be due to the small number of patients who completed the experiment. The problem of obtaining sufficiently large numbers of patients to obtain statistically significant data is a serious one. One may take patients as they come, over a long period of time, to increase the number of cases. This involves the risk that experimental conditions may change throughout the experiment, e.g., changes in the experimenter's methods and attitudes, changes in personnel, and so on.

SUMMARY AND CONCLUSIONS

To study the possible motivating effect of an easily visualized, graphic indication of progress during therapy, matched groups of 17 patients with an impaired hand were compared for improvement on five motor skills tests and recordings of finger movement. The control group was tested at the beginning and end of one month. The experimental group, in addition, was tested twice during the intervening time with recordings of finger movements, which they were shown. Of the 16 patients who completed the experiment, 11 were in the experimental group and 5 in the control group. Although the differences in improvement were not statistically significant, the experimental group showed uniformly greater improvement on all tests. Since some of the motor skills tests do not correlate highly with the tests of finger movement, this greater improvement cannot be attributed entirely to practice. We feel that the results lend encouragement to our hypothesis that additional motivation, afforded by an easily visualized record of progress, will lead to faster improvement in performance.

REFERENCE

1. The pursuit rotor apparatus was loaned by Prof. R. Dale Nance, University of Wisconsin-Milwaukee psychology department.

SCHOLARSHIP FUND

The United Cerebral Palsy Research and Educational Foundation, Inc., granted $10,000 for scholarships for undergraduate occupational therapy students for the academic year 1959-60. Twenty-eight colleges or universities offering approved curriculums each received the equivalent of 56.9 per cent of one year's average tuition costs for one student. This amount in some instances was awarded to one student only and in other cases was divided among two or more students. The initial screening of applications was the responsibility of each college or university scholarship committee and the director of occupational therapy at that institution. In this way, recipients were selected by those in a position to best know the potentialities and needs of the applicants. Applications were then sent to the American Occupational Therapy Association for final approval and forwarded to the United Cerebral Palsy Foundation. Awards from this fund were for tuition fees only.

Number of institutions paritcipating	28
Number of applications processed	172
Number of grantees	44
Number of states represented by recipients	23
Recipient's academic year	
Junior	18
Senior	20
Post-degree or Advanced Standing	0
Clinical Affiliations	6
Range of scholarship awards	$425.00-$642.00
Total amount awarded	$9559.00
Administrative costs paid to AOTA	$400.00
Total disbursement	$9959.00
Final balance on $10,000 grant	$41.00

Since 1954, $65,000 have been received from the Foundation for undergraduate scholarships and an additional $10,000 grant for the academic year 1960-61 has been announced. In behalf of the entire membership of the American Occupational Therapy Association sincere appreciation is expressed to the United Cerebral Palsy Research and Educational Foundation, Inc., for the continued interest in and support of the professional education of occupational therapists.

DURA-FOAM PRE-FABRICATED SHEETS

A New Fabricating Material for Occupational Therapists

JOSEPHINE C. MOORE, M.S., O.T.R.

Many new plastic materials have been introduced into the field of orthetics and adaptive equipment in the past few years. One of these is Dura-Foam. A number of therapists are acquainted with the original product, which was introduced into this country about three years ago by Colonel Harry F. Pierce[1] and Associates of the Dura-Design Plastics Company, Limited, Toronto, Ontario, Canada.

During the past few years Dura-Design Limited has continued its research program. They have attempted to produce a product which would be easier to fabricate and use in making rehabilitation devices for arthritics, polios, burn contractures, quadriplegics, various foot conditions and other disabilities. This newer product should capture the interest of all therapists working in rehabilitation centers or general hospitals who are from time to time called upon to use some material to make a semi-permanent or permanent device for a patient.

A brief history of this product should serve to acquaint therapists with both the old and new Dura-Foam. During World War II, Colonel Harry Pierce worked in the field of rehabilitation of the war injured. Here he saw a great need for a new material that could replace the paster casts and splints used in treatment. He found that these heavy white casts proved to be a psychological deterrent to the mental rehabilitation of many patients. Thus began twelve years of research to find a new material.

With the war's end, and the renewed growth in the pastics industry, he and his associates turned their attention to this field. Dura-Foam was finally developed.

This author had the privilege of being the first person in the United States to see the new material and to work with it. Within a year this material was introduced to many other therapists throughout the United States. These therapists came to know Dura-Foam as a lightweight, cold-mold material which could be fabricated at the patient's bedside, in the clinic, or at home in a matter of minutes. It was waterproof, allergy-free, non-toxic, washable, lightweight and yet strong. It was not white like plaster, but was easily colored to suit the patient's needs.

With this success at hand, Dura-Design Limited could well have settled back and rested on its laurels, but they continued their research program. This year the new Dura-Foam pre-fabricated sheets were introduced by Colonel Harry Pierce to the occupational therapy graduate class in adaptive equipment at Eastern Michigan University. These new sheets may well prove to be one of the best materials yet offered to therapists for making simple appliances, such as cock-up splints, writing devices, cup holders, forearm skates, and so on.

What, then, is the difference between the first Dura-Foam material of three years ago and this newer product? To explain this, one needs to compare the two materials, for both are available today. The therapist who has not had an opportunity to work with the older type may still desire to do so, and those who know of it will desire to experiment with, and to use the newer material.

THE ORIGINAL DURA-FOAM

Basic Materials

1. Jar of liquid plastic—D
2. Jar of liquid plastic—F
3. Catalyst
4. Plastic envelope with, or without one-eighth inch or one-fourth inch foam padding and reinforcing (according to the size of the project being made). These envelopes come in all sizes from five inches by eight inches to twenty inches by thirty inches with 19 sizes in between. The foam padding varies from one-eighth inch to one-fourth inch thickness according to the size of envelope used. The vinyl foam padding can be had in a variety of pastel colors.
5. It is best to have (or purchase from Dura-Design) a platen (10 inches by 20 inches) and a roller of some type (preferably a hollow plastic tube) which will not absorb heat.
6. Pair of heavy scissors.

General Procedure. (For specific directions, see instructions which come with each kit.)

Using a ballpoint pen, mark on the plastic envelope the pattern of the device or splint to be used for the project. Next, pour the catalyst into Jar "D". (If one is not experienced in the use of this material use less catalyst so that it will not set up as fast—or use all of it if one desires it to set up in 10 to 15 minutes. Next, pour jar "F" into "D" and stir thoroughly for just one minute. Immediately pour the entire liquid into the bottom of the plastic envelope. Place the envelope on newspaper and, using the roller, roll the liquid plastic mixture toward the opening of the envelope. (One may use side guides under the roller ends to assure a uniform thickness of Dura-Foam). Use the platen to apply final even pressure to the entire envelope. Allow material to set for at least two minutes, then make a test cut with scissors near the edge of the envelope. If the plastic is ready to cut, it will not ooze, and the reinforcing material will not protrude along the edge. When ready, cut out the pattern, and quickly mold it to the arm to be splinted or supported. Ace bandages (non-elastic)

or a similar material can be used to hold the appliance in place until it sets up firmly (about 15 minutes). Do not wrap the area too tightly or it will make impressions in the Dura-Foam.

Remove the bandage and Dura-Foam splint and trim off any rough areas, or excess, on a belt or band sander, or use medium grade sand paper. Straps of webbing, leather or rubber can readily be attached with Speedy rivets, aluminum or copper rivets. Drilling into the material can be done with an electric hand drill, drill press or by using a gimlet. Riveting must be done rather carefully to prevent fracturing the Dura-Foam.

In a fairly short time one obtains a finished product ready to use. If alterations are necessary, even at a later date, the material can be heated (immersion in boiling water, using a heat lamp or stripheater) and changes can be made by bending the area with one's hands to suit the patient's needs.

This in itself sounds fairly simple. However, many therapists have had trouble working with this material for one reason or another, and many have gone back to materials that are less apt to cause any difficulties in fabricating, yet may cost more, or take more time to make. The new Dura-Foam will give them a material that is extremely easy to work with.

THE NEW DURA-FOAM

Basic Materials

1. Pre-formed Dura-Foam sheets (thickness from 1.5mm, 2.0mm, 2.5mm, to 3.0mm. Available in three varieties of plastic mesh reinforcing, and either solid or perforated).
2. Vinyl foam padding with double-faced adhesive backing (comes in several widths, a variety of colors, and in either one-eighth inch or one-fourth inch thickness).
3. Jig or band saw for cutting out pattern (use extra fine blade) and sanding equipment for finishing edges.
4. A large flat pan for boiling water.

General Procedure

Mark out pattern with a ballpoint pen on the preformed Dura-Foam sheet. Cut out the pattern with a fine blade on a jig saw or a band saw.

Smooth edges with fine sandpaper, band or belt sander. Place preformed sheet in boiling water for a few minutes, according to the thickness of the sheet. (Do not apply padding before forming.) Remove the Dura-Foam sheet when it is fairly "flabby"—about thirty seconds to one minute—with tongs, pliers, or a similar tool. Quickly shake off the excess water, then, while the sheet is still warm, form it to the area being splinted. If one is forming the device to a tender area of the patient's body, lay a one-eighth inch layer of Vinyl foam padding on the part, then form the Dura-Foam sheet over this part. If modifications are needed, merely dip the area to be changed into the hot water, then reform it to meet the necessary requirements.

If the padding is necessary, cut out the pattern from the double-faced vinyl foam (known as Tuck-Tape), then remove the protective backing from the double-faced adhesive, and apply this padding to the Dura-Foam appliance. Soiled padding can easily be replaced by peeling off the vinyl foam padding and applying a new one.

Attaching straps, adaptations, or reinforcing the Dura-Foam appliance can be accomplished in a variety of ways. Dura-Design Limited markets a plastic cement which can be used for this purpose. Also the material can be laminated to itself, leather or webbing, by using some of the liquid Dura-Foam which is used to make the preformed sheets. Or, one can rivet (speedy rivets or regular rivets) parts onto the appliance, or fasten them on with aluminum or plastic fasteners, or birdcage snaps.

CONCLUSIONS

The new Dura-Foam prefabricated sheets are extremely simple to use. An appliance or "gadget" can be made quickly. Other advantages that Dura-Foam has to offer are:

1. Costwise, the material is not expensive, especially when one considers the fact that very few tools are needed to work with it, finishing is quick and easy, and it can be reformed at any time to allow for any neuromuscular changes.

2. It is one of the few materials that can be molded right on to the patient (in clinic, room, or in the home) without harm to the patient or the therapist. It is also one of the few materials which can be formed into compound curves, thus it can readily be formed to the many complex curvatures of the body.

3. This material will stand up under long and hard wear.

4. It can be obtained in various thicknesses and strengths to suit the needs of the project at hand.

5. It is available in a pleasing flesh color, or a variety of pastel shades. The vinyl foam padding is also available in similar colors. The padding is easily attached with no mess and easily removed.

6. These Dura-Foam preformed sheets are non-toxic, allergy-free, non-inflammable, lightweight, yet strong and durable. They are waterproof and are unaffected by oils, alcohols, ointment, and like materials. They are transparent to X-ray.

7. Dura-Foam can be utilized for making simple splints, and other devices such as cup, tool, utensil holders, writing devices or ADL aids.

Dura-Foam prefabricated sheets are one of the newer adaptive equipment media available today that should seriously be considered for use in our clinics and hospitals, especially by those therapists working in the rehabilitation of the physically handicapped.

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STUDY OF THE EDUCATION OF OCCUPATIONAL THERAPISTS IN THE UNITED KINGDOM *

Part II

MARIE LOUISE FRANCISCUS, M.A., O.T.R.†

THE CLINICAL FIELD OF OCCUPATIONAL THERAPY

Organization. Occupational therapy as a treatment service is organized in Great Britain under the national health services through the Ministry of Health for England and Wales, and the Secretary of State for Scotland. Responsibility is channeled through regional hospital boards, local hospital management committees, and lastly, house committees in each hospital. Employment regulations and professional qualifications for occupational therapists are established by the Whitley Councils for the Health Services, a part of the wage structure of the country. Seven grades of employment are specified in terms of years of experience and the number of therapists to be supervised. Salaries for each grade are established with a minimum to maximum range and include an increment schedule, with salaries ranging from 480 pounds ($1,344) per annum for the beginning therapist to 825 pounds ($2,310) per annum at the top of the scale for the highest grade head therapist. The number of working hours per week, annual leave allowances, sickness benefits and regulations concerning occupational clothing are determined by the Whitley Council.[1]

The scope of the field. Recent figures from the English and Scottish Associations of Occupational Therapists indicate membership in all categories to be about 2400, of which approximately 1500 are practicing in Great Britain.[2] About 300 new students enter the eight schools annually.

Occupational therapists are employed in hospitals, workshops, prisons, schools, clinics and in homebound programs covering the usual specialty areas. Treatment is carried out under medical prescription directed toward physical and psychological goals, as well as social and industrial resettlement. The most frequent plan of medical supervision is for the therapist to work directly under the guidance of the referring physician, although some of the leading teaching hospitals have well-established departments of physical medicine and rehabilitation within which framework the occupational therapist then functions. Occasionally, technical instructors are employed to assist occupational therapists, but this is a very limited practice.

Patient treatment. Treatment as observed in Great Britain is very similar to treatment in the United States with some differences in emphasis. The impression was received that more work is done in general hospitals, psychiatric institutions and rehabilitation centers, with fewer small specialty units, although a number of these certainly exist. There appear also to be greater numbers of geriatric and chronically ill patients on maintenance programs.

There are not large numbers of activity specialists so the techniques used by the occupational therapists cover a broad range, as previously noted in the educational requirements. Because of this and because the policy is to employ mainly certified therapists in occupational therapy departments, thus limiting the number of personnel, heavy work loads were noted and a great deal of the more general type of group work is done in addition to specific individual treatment.

A. *Physical restoration.* In the field of physical restoration, some excellent programs were observed based on highly specific treatment goals, well-planned and directed assessment and treatment procedures. Others of a more general and less definitive nature were also seen.

Impressive are some of the pieces of adapted equipment seen in use at several places: quadriceps, treadle and ankle rotation devices, wrist flexion - extension - pronation - supination (FEPS) handles, handles and pulleys on tools for bilateral work, resistance apparatus, and lively splints. Much of the equipment is either made or adapted within the departments themselves. A fine piece of therapeutic equipment, the "Oliver" rehabilitation machine,[3] designed by an occupational therapist and manufactured by a local company, incorporates an adjustable bicycle pedal unit and work table (which can be used for sawing, drilling, grinding, sanding, and polishing) with a seat unit which may also serve as a walker.

*This is the second part of a two-part article. Part I appeared in the May-June, 1960, issue of AJOT, page 123.

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A great deal of lower extremity work and heavy resistance exercise was observed. The usual methods of evaluation are used, although it is the usual practice to use the joint measurement and muscle testing records of the physiotherapist. Record keeping is kept to a minimum.

Activities of daily living and self-help devices play an important role in all programs; buses, bathrooms and kitchens are all utilized and adapted as necessary in the most practical ways. Almost every department visited had a kitchen for the retraining and/or assistance of housewives. Occupational therapists themselves do much of the home visiting to assess the physical environment to which their patients will return on discharge from hospital. In this way, treatment in the hospital can be specifically directed to overcome manifest problems.

Coordination and cooperation with the other specialists on the rehabilitation team are accomplished through the usual channels. An interesting and unique plan for the orientation of patients to occupational therapy was observed at one rehabilitation center. Once each week, the head occupational therapist meets with all new patients who are referred for treatment and discusses with them as a group the purposes of occupational therapy, the method of functioning of the department, and what is expected of them as members of the workshop community.

If one could sum up in one word the theme of some of the outstanding departments seen in this country, this observer would choose the word *practical* — down-to-earth, without fancy equipment, and directing the treatment to community adjustment.

B. *Psychiatry* in Great Britain appears to lean in the direction of Meyerian orientation, dynamic in concept, but without the Freudian or psychoanalytic emphasis. Psychotherapy, chemotherapy, shock therapy, psychosurgery (leucotomy), and occupational therapy are all used, with noted trends toward group techniques and means for assisting more patients with limited number of personnel. Social psychiatry and varying interpretations of "therapeutic community," decentralization of patients by means of day hospitals, out-patient clinics for patients who can live at home, the open ward system, resettlement units and ex-patients' clubs are all directed toward increased patient responsibility in the treatment process.

Characteristics of occupational therapy are in line with the above and appear to emphasize group activities and approach, with awareness of the needs of the individual in the groups. Treatment is based on symptomatic needs rather than on dynamic concepts. Emphasis is not placed on relationships as these are considered to be a natural concomitant of the group situations. Aside from the usual arts and crafts, physical and social recreation play an important role, as do music, gardening, cooking, hospital industries and factory-out-work. The latter is a definite trend that has taken hold and is increasing. Small assembly units of the sheltered workshop variety are undertaken. Patients are paid sometimes on a piece rate, sometimes on a token basis for their work. Patients are also paid token amounts when they work in the industries of the hospital. Most hospitals visited had a kitchen unit within the occupational therapy department in which patients do light cookery and sometimes prepare full meals. Other activities seen were singing groups, patient pantomimes, dances, physical recreation, games, social recreation clubs and outings. At one institution, one of the buildings of the occupational therapy department was built entirely by patients.

C. *Mental deficiency.* At the two institutions visited for the treatment of mentally deficient patients, occupational therapy plays a major role. At one of these, the entire educational program for the younger children is arranged and carried out by therapists. In addition, activity programming is done for four other groups of patients: high grade, middle grade, low grade, and a small geriatric cottage unit. About one-third of the patient group participate in occupational therapy and many of the rest, if able, contribute to the maintenance of the hospital community, being paid token amounts for their contributions. In the second institution, the educational program for children is one unit of the occupational therapy department, but instruction is carried out by educational specialists. High grade females work in hospital industry; middle grade male and female patients work in occupational therapy units, in sheltered employment, and some work daily in the nearby community, returning to the hospital at night.

D. *Geriatrics.* Groups of older people were seen in practically every hospital visited, with treatment directed toward alleviation of handicap, psychological adjustment or maintenance.

An interesting program was described in a paper presented by Cosin and Ford, at the second national congress of the Association of Occupational Therapists (England), May 1959.[4] The program described involved a dynamic quadruple assessment of the patient in regard to: (1) medical pathology, (2) sociological problems inside and outside of hospital, (3) psychological problems, and (4) physical problems which result from the first three. This program is structured toward increasing independence and social competence by withdrawing facilities for dependency care, with patients moving from acute wards to

rehabilitation wards to a half-way house to a day hospital. Occupational therapy was described as including assessment, symptomatic treatment, socialization, activities of daily living, and prevocational.

Day hospitals and social centers are available to meet the needs of the aged in the community.

E. *Pediatrics.* No pediatric wards were seen or mentioned in any of the hospitals visited, with two exceptions: one a school for cerebral palsied children, and the second a children's unit in one of the psychiatric hospitals. Young adolescents were observed in several situations mixed in with adult patients. The program of one children's hospital as described in a paper at the second national congress referred to above was directed toward meeting the psychological needs and minimizing tensions of children in the hospital through satisfying relationships and an activity program of toys, books and other material in terms of growth and development needs.

F. *Resettlement.* Social and industrial resettlement of the patient in his community is the end goal actively worked toward by all good occupational therapy departments and becomes the guiding theme in treatment. When the patient is ready for medical discharge from the hospital, he may or may not be ready for full employment.

During the course of treatment an employee of the Ministry of Labour and National Service, the disablement resettlement officer, coordinates with the treatment personnel in assessing the patient's employment capacities. He is an active member of the rehabilitation team and in leading hospitals attends conferences and visits patients under treatment and assessment in occupational therapy. Cooperating with employment exchanges, he locates suitable employment for the patient. If, however, the patient is not prepared for direct employment, and further assessment or work build-up are necessary other facilities are available (industrial rehabilitation units and government training centres), and the disablement resettlement officer coordinates these.

SUMMARY

It should be emphasized that the programs described here are all those of teaching departments of occupational therapy. They are, therefore, a highly selected group, and it can be assumed are representative of some of the best treatment programs of the country. In addition, the selectivity of the observer must be acknowledged, for many times unique or particularly outstanding features in one or several programs have been emphasized. The picture presented, therefore, is not an average one, but is a sampling of the best.

In preparing this report, every effort was made to observe and interpret what appear to be the major requirements of patient treatment through occupational therapy in Great Britain and the essential details of the educational system. It was difficult at times to understand and correctly interpret since the background of the observer was based on education and experience in another country and because of biases that may lead an observer to "see" what he is looking for and to miss the obvious. If misinterpretations have occurred, apologies are due, and it is hoped that the therapists of the host country and any others reading this report will understand the difficulties and accept it with charity and for-bearance.

CONCLUSION

In the foregoing chapters an attempt has been made to describe briefly the system of occupational therapy education in the United Kingdom and the clinical fields of service for which therapists are being prepared. Emphasis in the total programming is based on two areas of concern, the psychological and the physical, with all other areas of specialization stemming from them.

The schools, the clinical field as a whole, the professional organizations are constantly evaluating programs and shifting emphases in line with developments in the medical field toward improved services for patients. One major educational shift in recent years was the recognition of the unity of mind and body leading to the discarding of educational requirements which permitted undergraduate specialization in either psychological or physical areas of treatment. All students must now complete the total qualification.

In any educational program, one should be able to identify not only areas of strength, but also those areas needing improvement and further strengthening. The latter are perhaps more difficult for an observer from outside of the country to correctly define and interpret. It should also be recognized that observations were based on a quite limited sampling which further reduces validity.

Within these limits, the following appear to be some of the major strengths of occupational therapy education in Great Britain:

1. The broad usage and excellent instruction in a wide variety of therapeutic occupations and group activities.
2. The orientation given the student during a probationary period in the occupational therapy school.
3. The development of clinical experience running concurrently with theoretical and practical instruction.
4. The development by the student of leadership and teaching techniques through active participation and practice of these skills in school as well as clinic.
5. The recognition by school personnel of the over-all needs of the student as a developing individual, and the inclusion of a broad variety of extra-class activities and

experiences to assist the student toward well-balanced development and self-concept.

By the same token, the following seem to the observer to be areas requiring more attention and concern:

1. The clearer definition of the clinical experiences to be obtained by students at different levels of academic preparation.
2. The guidance of students to increased specificity in individual treatment programming.
3. The guidance of students to foster self-responsibility and initiative at the same time offering sufficient framework for clear role definition and the stimulus of accomplishment.
4. The arrangement of the fall qualifying examinations to avoid disruption of the academic program just as the term reaches a point of stabilization—seven or eight weeks after it starts.
5. The need for post-graduate offerings in areas of specialization, linked to universities when feasible.

Excellent progress has taken place in the development of occupational therapy in Great Britain in a relatively short period of time, approximately thirty years. The professional leaders and the therapists of the country can well be proud of their accomplishments and of the quality of education in evidence. Treatment programs in patient centers also show a high standard of accomplishment, the result of hard work and persistent effort. Medical understanding and utilization of occupational therapy are progressing, but still require concentrated effort from the therapists in many locations.

Professor Brand Blanchard of Yale University has stated that a student should leave college with a sense of what is central and what is trivial, and with "this most infallible mark of the educated mind—the ability to put the issue simply, offer its evidence economically, face difficulties fairly and draw a firm conclusion.[5]

These words are keys to the needs for the ongoing development of our profession, which has undoubtedly proven itself, but must now improve itself. These must become the responsibility of all occupational therapists throughout the world. These words are keys to education, clinical practice, research and communication. That the way has opened, through the World Federation of Occupational Therapists, for us to join hands across national boundaries, should make our task easier. For we can now think, plan, share and develop together as we strive for improved education of our students and treatment procedures for our patients, encompassing research and an accumulating body of knowledge.

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HOSPITAL DEPARTMENTS OF OCCUPATIONAL THERAPY VISITED

Astley Ainslee Hospital, Edinburgh, Scotland

Bangour Hospital, Broxburn, Scotland

Botley's Park Hospital, Chertsey, England

Crichton Royal Hospital, Dumfriis, Scotland

Derby Royal Infirmary, Derby, England

Farnham Park Rehabilitation Centre, Farnham Park, England

Kings College Hospital, London, England

Kingsway Hospital, Derby, England

Marlborough Day Hospital, London, England

Maudsley Hospital, London, England

Medical Rehabilitation Unit, Camden Town, London, England

Newchurch Hospital, Culcheth, Warrington, England

Newsham General Hospital, Liverpool, England

Pastures Hospital, Derby, England

Promenade Hospital, Southport, England

Psychiatric Day Hospital, Liverpool, England

R.A.F. Medical Rehabilitation Unit, Chessington, England

Royal Mental Hospital, Aberdeen, Scotland

Royal Mental Hospital Group, Edinburgh, Scotland

Royal Northern Hospital, London, England

Shenley Hospital, Herts, England

St. Andrews Hospital, Northampton, England

St. Thomas and Royal Waterloo Hospitals, London, England

Westerlea School for Spastics, Edinburgh, Scotland

Whiston General Hospital, Whiston, England

Pi Theta Epsilon . . .

(*Continued from page* 252)

All four chapters have adopted pins to be worn on uniforms in affiliations and in practice. We feel that this is one step toward national unity. It is hoped that other schools will be interested in forming a chapter of Pi Theta Epsilon. The near future should bring a national organization which will further strengthen the contribution that Pi Theta Epsilon can make to the field of occupational therapy.

DRESSING TECHNIQUES FOR THE SEVERELY INVOLVED HEMIPLEGIC PATIENT

GLADYS BRETT, O.T.R.*

One of the major difficulties in activities of daily living for the severely involved hemiplegic patient is in the area of dressing. Through repeated use and continuous modification of various methods used with a large number of hemiplegic patients, we have formulated the following procedures. From our experience, we have found these to be the most efficient techniques used by the patient to gain independence.

GENERAL CONSIDERATIONS

1. Verbal directions must be clear and concise, and the same directions given repeatedly.
2. Day after day repetition is often indicated. With very confused patients, it is often advisable to see the patient for training on the ward in the morning when it is the appropriate time to get dressed.
3. Articles of clothing should be placed within easy reach of the patient and he should be encouraged to do as much for himself as possible.
4. Reaching tongs of all types are valuable in securing objects as well as assisting in dressing activities.
5. No adapted equipment should be furnished unless absolutely necessary.
6. With patients demonstrating impairment or loss of sensation, precaution must be used to prevent bumping of the extremities.
7. With patients demonstrating imbalance, precaution must be used to prevent falling.
8. Preferably, the patient should sit in a sturdy chair with arms, placed against a well to prevent slipping, or in a wheelchair. If a wheelchair is used, brakes *must* be in locked position at all times. If the patient is not able to sit in a chair, or demonstrates considerable imbalance while sitting, dressing can be accomplished completely or partially on the bed.
9. In any dressing activity which involves crossing the hemiplegic leg over the good leg, if there is difficulty in keeping the legs crossed, either of the following may be helpful. If patient is seated in a straight chair, place a small stool in front of the chair to put feet on so the bent knee will be in a higher and more secure position. If wheelchair is used, footrests should be in a down position.

SHIRTS

Procedure for Putting On

Method can be adapted for jackets, robes and dresses opening completely down the front. If possible, the garment should have loosely fitting sleeves and be a size or two larger than usually worn. If a dress, it should have a full skirt or should slip easily over the hips, and be made of wrinkle-shed cotton, nylon or seersucker.

Method I (preferred method)

1. To prevent the shirt from becoming twisted, grasp collar and shake shirt out with good hand. Position shirt on lap with *inside* of shirt *up*, collar toward chest. It is sometimes helpful for patient if it is pointed out that in this position the label inside the shirt collar is facing up.
2. With good hand, position shirt sleeve for affected side so opening is as large as possible and as close to the involved hand as possible.
3. Using good hand, place involved hand into shirt sleeve opening. Then, work the sleeve up over the elbow by pulling on garment. Pushing garment up onto arm, or threading arm through with good hand, is more difficult.
4. Put good arm into sleeve, raising arm up to "shake" sleeve into position past the elbow.
5. Gather the garment up the middle of the back from hemline to collar with the good hand, then raise the shirt over head. Duck the head and lean forward passing the shirt over the head.
6. Adjust shirt by leaning forward and with good hand work shirt down past shoulder on both sides. Reach to back and pull tail of shirt down. Line up shirt fronts for buttoning.
7. Button shirt starting with bottom button, which is in complete sight of patient.

Method II. Used for patients who get shirt twisted, or who have difficulty in "shaking" sleeve down on unaffected extremity.

1. Position shirt as in Steps 1 and 2 of Method I.
2. Using good hand, place involved hand into shirt sleeve opening and work sleeve onto hand. Do *not* pull up past elbow.
3. Put unaffected arm into sleeve and bring arm out and up to a position of approximately 180° shoulder abduction. The tautness of material from the unaffected arm to the wrist on the involved side will bring the sleeve into position. Lower arm, and then work sleeve on involved arm up over the elbow.
4. Proceed as in Steps 5, 6 and 7 of Method I.

Method III

1. Position shirt and work onto arm as in Steps 1, 2 and 3 of Method I.
2. Position sleeve on affected side up to the shoulder.
3. With good hand, grasp the tip of the collar which will be on the unaffected side, lean forward, and bring arm over and back of head to position on unaffected side of body. This prevents patient from reaching behind head to fumble for garment which he cannot see.
4. Put good arm into the armhole. It is generally better to direct arm outward and up.
5. Adjust and button as in Steps 6 and 7 of Method I.

Comments: Fastening of cuff on unaffected side may be accomplished by one of the following:

1. Button before putting garment on. If cuff is too small, sew button on with elastic thread.
2. Button with button hook attached to table with suction cup.
3. Sew small pieces of Velcro to inside of cuff. Patient rolls arm to fasten.

Procedure for Removing

Method I (preferred method)

1. Unbutton garment.

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2. Lean forward and make sure garment is free in the back.

3. With good arm gather the material up in back of neck (or take hold of collar). While leaning forward, duck the head and pull material over the head.

4. Remove shirt first from the good arm and then from the affected arm.

Method II

1. Unbutton garment.

2. With good hand, throw shirt back off shoulder on both sides, and pull down on cuff on unaffected side with the hand. Sleeve is worked off by intermittently shrugging shoulder and pulling down on cuff.

3. Lean forward, bring shirt across back and remove from affected arm.

PULL-OVER SHIRTS

Procedure for Putting On

Method I

1. Shirt is positioned on lap, bottom toward chest and label facing down.

2. With good hand, roll up bottom edge of shirt back all the way up to the sleeve on affected side.

3. Position sleeve opening as large as possible. Using good hand, place affected arm into sleeve opening and pull shirt up on to arm past the elbow.

4. Insert good arm into sleeve.

5. Adjust shirt on involved side up and onto the shoulder.

6. Gather shirt back with good hand, lean forward, duck head and pass shirt over head.

7. Adjust the shirt.

Procedure for Removing

1. Starting at top back, gather shirt up, lean forward, duck head and pull forward over head.

2. Remove from good arm and then from affected arm.

TROUSERS

The same method can be adapted for shorts or women's underwear. A button fly front may be easier to manage than a zipper unless patient can stand to fasten top button and zip. It is recommended that trousers be a size or two larger than is usually worn.

Procedure for Putting On

Method I (sitting position)

1. Patient sits in straight arm chair or in wheelchair.

2. Good leg should be positioned directly in front of mid line of body with knee flexed to 90 degrees. Using good hand reach forward and grasp the ankle of involved leg, or portion of sock around ankle, and lift the affected leg over the good leg to a crossed position.

3. Slip trousers onto hemiplegic leg only up to a position where the foot is completely inside of trouser leg. Do *not* pull up above knee or difficulty will be encountered in inserting unaffected leg.

4. Uncross the affected leg by again grasping the ankle or portion of the sock around the ankle.

5. Unaffected leg is inserted and the trousers worked up onto hips as far as possible.

6. If wheelchair is used, footrests are now placed in an "up" position.

7. Patient now stands (if he is able to do so safely) and pulls trousers over hips. To prevent trousers from dropping as the patient stands, the affected hand is placed in the pocket, or one finger on affected side is slipped into belt loop, or suspenders may be used and pulled into position over the shoulder before patient stands.

8. Patient should sit down to button the front.

Method II. Used *only* for patients in wheelchair with brakes in locked position, or in straight arm chair only if it is secured against the wall. This method is for patients who cannot stand.

1. Position trousers on legs as in Steps 1-5 above.

2. Foot rests remain in *down* position. Patient elevates hips by leaning back against chair and pushing down with good leg. As hips are raised the trousers are worked over hips with good hand.

3. Patient lowers hips back into chair and fastens trousers.

Method III. Lying position, this is generally more difficult for the patient. If possible, the bed should be gatched so the patient is partially sitting.

1. Using the good hand, the affected leg is placed in a bent position and crossed over the good leg. The good leg may be partially bent to prevent affected leg from slipping.

2. Trousers are positioned and worked onto affected leg first (only to knee). Leg is then uncrossed.

3. Unaffected leg is inserted and trousers worked up onto hips as far as possible.

4. With good leg bent, press down with foot and shoulder to elevate hips from bed and with good arm pull trousers over hips, or work trousers up over hips by rolling from side to side.

5. Fasten trousers.

Procedure for Removing

Method I

1. In a sitting position, patients unfastens trousers and works them down on hips as far as possible.

2. Patient stands and lets trousers drop past hips, or works them down past hips.

3. Trousers are removed from unaffected leg.

4. Patient crosses affected leg over good leg, removes trousers and uncrosses leg.

Method II

1. In sitting position, patient unfastens trousers and works them down on hips as far as possible.

2. With foot rests in *down* position patient leans back against chair, pushes down with good leg to elevate hips, and with good arm works trousers down past hips.

3. Proceed as in Steps 3 and 4 of Method I.

Method III (lying position)

1. Hips are hiked as in putting trousers on in Method III, Step 4.

2. Trousers are worked down past hips, unaffected leg is removed and then affected leg is removed.

BRASSIERES

Procedure for Putting On

1. Brassiere is hooked in front and slipped around to the back (at waist line level).

2. Affected arm is placed through the shoulder strap and then the unaffected arm is placed through the other strap.

Comments: Elastic may be added to the straps for ease in getting on and off.

STOCKINGS

Procedure for Putting On

Method I

1. Patient sits in straight chair with arms, or in wheelchair.

2. With good leg directly in front of midline of body, affected log is crossed over it.

3. Top of stocking is opened by inserting the thumb and first two fingers near cuff and spreading the fingers apart.

4. Stocking is worked onto the foot, taking care to eliminate all wrinkles.

SHORT LEG BRACES

Procedure for Putting On

Method I

1. Patient sits in straight chair with arms or in wheelchair.
2. Good leg is brought to a point directly in front of the midline of the body. Hemiplegic leg is crossed over good leg.
3. Tongue of shoe is pulled through the laces so it does not push down into shoe as brace is put on.
4. Holding the short leg brace by the top inside portion of the metal bar with the good hand, the brace is swung back and then forward so the heel is between the uprights. Shoe is swung far enough forward so the toes can be inserted into the shoe. Still holding onto upright bar of brace, the shoe is turned inward so the toes will go in at a slight angle preventing catching the toes at the sides of the shoe.
5. Brace is pulled up onto leg as far as possible. If difficulty is encountered in getting the brace up far enough on leg, hemiplegic leg can be elevated to a higher position by pulling up further on the crossbar, making the foot easier to slip into the shoe. The brace can now be held in position by pressure against the crossbar between the affected leg and the unaffected leg, while a shoe horn is inserted flat and directly under heel in back. If the patient has difficulty in keeping the brace on while inserting the shoe horn, the hemiplegic leg should be elevated by pulling up on crossbar to a position where ankle of hemiplegic leg is resting against knee of good leg with uprights on each side.
6. By holding upright, affected leg is uncrossed and positioned at 90 degree angle to the floor. The shoe horn is now in a position where the patient's heel is pressing on it. Intermittently, pressure is directed downward on the knee and the shoe horn is moved back and forth by the unaffected hand until the foot slips into the shoe.
7. Laces and straps are fastened. Elastic shoe laces or one of the many methods of tying a bow wtih one hand is used.

Procedure for Removing

Method I

1. Cross affected leg over good leg.
2. Unfasten straps and laces.
3. Push down on upright until shoe is off the foot.

Method II

1. Unfasten straps and laces.
2. Straighten affected leg by putting good foot behind heel of shoe and pushing forward.
3. Push down on upright with hand and at the same time push forward on heel of brace shoe with unaffected foot.

LONG LEG BRACES

Procedure for Putting On

This procedure is very difficult for the severely involved patient, but we have found that the following directions will enable some patients to manage the long leg brace independently.

Method I

1. Patient sits in straight chair with arms, or in a wheelchair with the foot rests on involved side in an *up* position.
2. Brace is placed next to patient's hemiplegic side in a *locked* (straight) position. Tongue of shoe is brought up through the laces.
3. Good leg in this instance is *not* moved to mid line of body position. Hemiplegic leg is crossed over good leg so lateral side of ankle is positioned against lower one-third of the femur.
4. Top of inside portion of brace is grasped in good hand and placed under leg, well up under the thigh. Thigh strap is pulled out so it will not be under leg, as leg is inserted into the brace.
5. Patient uncrosses leg by grasping the ankle or sock and positions foot between lower uprights so toes are resting inside of shoe opening.
6. Patient releases lock and bends brace by pulling up on upper inside upright near brace joint. When lower portion is in a position where patient can reach to the foot, shoe horn is inserted in a position flat and directly behind the heel. Foot rest is now placed in *down* position, brace is positioned on it bent to a 90 degree angle.
7. Patient pushes forward on heel using good hand and intermittently presses downward on knee and pulls shoe horn forward until foot is in shoe.
8. Knee strap is fastened only tight enough so that one finger can be inserted easily along upper and lower edges of knee pad.
9. Thigh strap is fastened.
10. Shoe laces are secured.

Procedure for Removing

Method I

1. Unfasten all straps.
2. Using good foot, push heel of shoe on brace forward and hold in place. Pull upon hemiplegic leg by grasping ankle or sock and bring to a crossed position over unaffected leg as in putting brace on.
3. Remove brace and uncross leg.

The author wishes to express her appreciation to the entire occupational therapy staff of Highland View Hospital, and especially to Mr. James White, OT aide, for their contributions to the foregoing article.

Activity Programs . . .

(*Continued from page* 248)

SUMMARY

The two crucial areas of conflict that this plan would aid in solving are: (1) the over-fragmented day planned for the patients, resulting from piecemeal activities planned at the administrative level. (2) Frequent rivalries among professional sub-groups due to an over-identification with their own profession.

REFERENCES

1. Henry, Jules, M.D. "The Formal Structure of a Psychiatric Hospital," *Psychiatry*, Vol. 17, 1954, pp. 139-151. "Types of Institutional Structure," *Psychiatry*, Vol. 20(February) 1957, pp. 47-50.
2. Granger, Beverly J., and Joan M. Doniger. "A New Perspective on Training and Practice in Occupational Therapy," *American Journal of Occupational Therapy*, 12:2 (March-April) 1958.

HOMEMAKER REHABILITATION

A list of publications entitled "Vocational Rehabilitation of Handicapped Homemakers" is available from the School of Home Economics, University of Connecticut, Storrs, Conn. The eight-page folder includes annotated lists of motion pictures, colored slides, bulletins, posters, exhibits and bibliographies on work simplification in the area of child care for the physically handicapped homemaker.

NATIONALLY SPEAKING

From an AJOT Article

My authors christened me "A New Approach in Ocupational Therapy by Using Group Dynamics on a Group of Depressed Patients." I don't think they realized what a mouthful my name was; they always called me the "AJOT article." They really did not want to write me; they were coerced into it. At a staff meeting, the medical supervisor at Central State observed that only the occupational therapists had failed to write an article about one of the several research projects being conducted. June, the effusive one, had spoken up. "But we are doers, not writers." The hush that followed that blatant remark convinced her that rationalizations do not suffice for deeds. Enlisting the help of Fred, another OT, and consulting with the medical supervisor and the psychologist, they got me written, although it was not easy. I was bundled off in a large manila envelope and after a rough ride I landed on the editor's desk. She made a face when she saw my title, but read me all the way through.

Then she wrote a letter to a group of division editors, asking them to read me carefully. She said the material would need some editing, but she would like an evaluation of the article for AJOT before asking my authors to revise me. I learned these division editors are all volunteers as are all other staff members except the editor and the assistant editor, and that the space for the editorial office in Milwaukee is donated by the North Shore Publishing Company.

I was mailed to a distant city where the division editors read and discussed me. I certainly learned a lot about myself listening in. Then the editors wrote a detailed criticism and sent me back to the editorial office. Since I was considered sound in theory and new in approach, the editor was happy to write my authors that I could be accepted for publication if they would revise me as the division editors suggested. She added a few editorial suggestions of her own and asked for a shortening of my title.

So back I went to be groomed and polished. My authors were wise enough to again consult their medical superintendent, and this time the work went better. But after being pulled apart and retyped, and journeying back to the division editors once more, I was glad to get back to the editorial office and rest in a file marked "April." However long before that time both the editor and her assistant reread me to make sure all my paragraphs and sentences were structurally correct, that my commas were in the right places and that no one had mis-spelled a word. Also most of my capitals were made into lower case.

Now I was ready for the printer and the first of February I was sent to a room they called the "shop." What a noisy place that was, with linotype machines whirring and presses rumbling. I was reduced to rows of metal letters which were lined up on trays called "galleys," and a heavy rubber roller passed over me so that my words came out on a long piece of paper.

The editor read these "proofs" to correct typographical errors and sent me back to the shop. The corrected proofs were checked again and sent to my authors for a double-check.

One day the editor t o o k me home. She spread me out on her dining room table and cut me into sections which she pasted onto a large sheet of paper. This was a "dummy" of the magazine, and I got a good idea how I would look in print and became quite excited. I was the third of six articles, then followed "Nationally Speaking," general news, conference highlights, delegates reports, book reviews, classified and display ads and finally the covers were added.

Back I went to the printer, who made me up into pages, just like the dummy sheets. The editor and her assistant looked at the pages to see if they were in proper order and spaced correctly, and then I went to press. I was locked up in a 16-page form, and then this big roller roared over me. I came out the other side on nice shiny paper and was stacked away in a box to be sent to the bindery. There they cut my pages apart and bound me into a book.

Back at the shop in colored cover, I was stuffed into envelopes and bundled into mail sacks for travel all over the world. All told I went to the fifty states and twenty-eight foreign countries. I thought that was pretty good for a little country girl from up-state.

All in all I am most grateful to my authors for this varied and interesting experience. As an article in AJOT, I can now rest quietly on the reference shelves until some occupational therapist refers to me when writing a new article. I am also used as a study in OT schools, so I get to meet the new students coming along. I am proud to be able to serve them.

The *BOOK LOAN* as offered by the American Occupational Therapy Association is a membership service. The books available are mostly pamphlets and manuals not easily obtainable. The material is kept up to date and is sent out by request for a period of two weeks. A mimeographed copy of the book loan publications is available from AOTA.

EDITORIALS

LOOK AGAIN AT OUR FOUR CHIEF FUNCTIONS IN PSYCHIATRY

Does the term occupational therapy in Connecticut mean the same as rehabilitation therapy in California? Do the activity therapists of Pennsylvania compare with the adjunctive therapists of Kansas? What are the essential differences in function of psychiatric occupational therapists in federal, state and private situations? What does all this semantic confusion relating to occupational therapy in psychiatry mean? Many of us concerned with psychiatry have puzzled and reflected on these questions over the past years as we have worked hard on many fronts for a more clearly recognized function.

Our careless use of words and small thinking has often been a contributing factor to the confusion that has blurred our vision for seeing our four-pronged function. An example of both carelessness and small thinking within the confines of my own individual professional sphere of influence occurred recently. An OTR adjunctive therapist invited as a guest lecturer asked students for examples of compulsive activities. The responses were limited to those of an "artsy-crafty" nature. Why? We find examples in the broader sphere of influence represented by collective groups of occupational therapists in committee reports. For example, the record shows an agenda item for our governing body (meeting June, 1960) as occupational therapy *in* activities therapy. Who picked the preposition "in" and why wasn't the preposition "as" used? Words, it is true, do not wholly describe a function, but they can and do structure thinking. As we look again at these four basic functions, let us keep in mind the many different words that have gone into their development.

It is time to become more careful with our use of words. It is time to raise our sights! It is time to listen carefully as psychiatric occupational therapists speak out on their four functions with different words which reflect their experience. What is really happening in the midst of this semantic confusion?

A reintegration is occurring. A whole is being re-formed from the parts. This whole has been threatened, bumped, bounced and tested, but has held. Two of the developmental conditions of our profession which have produced these threats are worth looking at. For simplicity, call them first the federal, and second the state, influences. Specifically, neither the quantity nor quality of OTR's was sufficient to meet the challenge of World War II. Therefore, in federal-military hospitals personnel with comparable general education, and often with professional training from the broad field of education, were brought to work side by side with therapists. They brought with them educational skills (methods of teaching together with a level of competence in activities of physical education, manual arts, fine arts and music). The occupational therapist brought medical information and theory of application of therapy through occupation, as well as a jack-of-all-trades-master-of-none background of activity skill. Together they did a whole job. What happened to occupational therapy within this administrative setting? It was confined to rather specific medical direction, as contrasted to the recreation, volunteer, library and other services known in the Navy in 1944 as "welfare and recreation."[1] As a result of this confinement, many specifics were pinned down and written up. Techniques were refined and analyzed with greater detail than previously, and actually our profession achieved a new degree of depth. This was good until the depth facet of our profession showed signs of wanting separation from the breadth.

Several examples of this influence exerting itself as a threat were: the emergence of a subgroup within the profession (World War II occupational therapists); distinctions between types of practice in our profession as specific and nonspecific, or functional versus diversional, came into evidence. A certain tonal quality indicating lower prestige value seemed to accompany the terms non-specific and diversional. This had a strong and subtle effect on our profession that was threatening and was climaxed in heartfelt words from a national figure, a well-known O.T.R., in the late 1940's who said "I believe we must delimit our function."

A second example of this struggle of separating out of two distinct functions in occupational therapy practice within psychiatry occurred in the state mental hospitals of our land. Personnel associated with state hospitals had lower prestige value than personnel associated with the military hospitals. Yet the sheer numbers of occupational theapists who did professional work in this setting made them a most important influence in the development of our basic functions. It is also important for all occupational therapists to remember, in spite of the low prestige value and the fact that the typical state hosptial of the past is a dying institution, until recently over 90 per cent of the mentally ill in our great country were cared for and treated (when treatment was available) in state-like hospitals (some were county institutions of comparable size and organization.)

1. There are variations in names in different branches of the Service, and the Veterans' Administration currently uses the term "Special Services."

What did the occupational therapists do in our country's state hospitals? What was their function and contribution to our profession? Essentially they did two things — some administered programs to many and some limited their contribution to few with greater intensity. Here the administrative activity divisions often were work and play, or occupational therapy and recreation. Most occupational therapists seemed to identify more closely with the work side of this structure, but oddly enough they did it through use of traditional recreational activities as sewing, art, weaving, woodwork, and so on. (Perhaps because changing work assignments from production to therapy emphasis was so formidable a job in view of the shortage of well-trained professionals within these institutions.)

In the state hospitals the two functions, levels of depth and administration, are very clearly seen. The threat here stemmed from the very plight of the state hospitals themselves which, boiled down, was too many patients and not enough money resulting in staff shortages. What did the occupational therapists who worked under this influence do? They became good *parts* (therapeutic occupational therapy; occupational therapy on a receiving ward; occupational therapy in convalescent service; occupational therapy with shock patient) and good *wholes* director, occupational therapy department; coordinator, occupational therapy and recreation; integrator of work and play activity adjunctives). Was it occupational therapy function, however, to do a good job of treatment with a few or to administer a good program to many? A wedge between these parts and wholes represents itself as a threat through small thinking and careless expressions of "anyone knows you can't treat hundreds of patients by yourself" and "people who administer programs aren't therapists, they are just interested in making more money." These sorts of comments also had accompanying tones that made it very evident that these were two groups — the bad, money-mad administrators and the good, dedicated occupational therapists.

The forces that have influenced us to develop our other two big functions in psychiatry are not as clear-cut as the military and state hospital forces. Yet they are forces that have consistently and persistently been in effect since the crisis of World War I gave birth to our profession. It is sometimes important for us to remind ourselves that our profession came into existence and made its greatest strides in periods of crises. The current shortage of O.T.R's. and student scholarship applicants, coupled with the position we are in to work with skills specialists in the arena of activities therapy, adjunctive therapies, rehabilitation therapies and the like, puts us in a crisis state for our third function: education. We must extend ourselves at different levels through teaching!

Think for a moment of the influences upon us to teach. We *teach patients* new patterns of behavior. We *teach physicians* by demonstrating good treatment, by discussing implications of therapeutic aims through occupational therapy. We *teach assistants* — nurses, skill specialists, volunteers — to carry out parts of the job. Some of us *teach the on-coming generation of occupational therapists* through staff in-service programs, through skilled supervision, through clinical practice or through curriculums of occupational therapy in the various colleges and universities offering professional education for our field. Careless use of words, together with a low sight level, can be easily found in relationship to our function of education. Limitation of teaching techniques is reflected in our over use of words like "lecture," "indoctrinate" or "didactic." A congratulatory note on the AOTA text, "Changing Concepts and Practices of Psychiatric Occupational Therapy," expressing enthusiasm for the contributions of this book to all of occupational therapy brought forth a comment to the effect of "yes, it will be valuable to psychiatric occupational therapists." Do we want to limit our educational function as we develop it in psychiatry *from* the rest of our profession, or shall we raise our sights to the potential influence we might exert in extending educational skills we learn in psychiatry *to* the rest of our profession?

Research, our fourth function, contains a strong element of exploration and curiousity. It begins with a desire to do things better, to look a little deeper for reasons, to try an experimental approach to prove the value of some technique. Research usually is associated with graduate work in the typical university setting and it is to be expected to grow as one of our functions in relation to the proportion of O.T.R. candidates for graduate work who bring their graduate experiences with research back into our field. A strong additional force, however, in psychiatry is the current and growing practice of having research directors in many of our psychiatric hospitals. Here the growing opportunity is becoming available to work on research teams, to suggest concerns, hypotheses and interests from our own profession that could be researched and studied for improved patient treatment as well as validation of our own professional procedures.

Now in the Post-Allenberry era of enlightened occupational therapy in psychiatry amidst the semantic confusion of activity therapy, adjunctive therapy, rehabilitation therapy and the like, we are about to have a psychiatric consultant

attached to our national office staff. We hope this person will not differentiate psychiatry from rehabilitation, as the early job description from our official publication seems to suggest. When is psychiatry not rehabilitation and vice-versa? It seems important and timely for us to reassess, restrengthen and reaffirm during this period our four chief functions in psychiatry—levels of depth, integration of the parts, extending our services, and exploring for better ways of doing things—or in our more refined professional jargon: treatment, administration, education and research. As we rededicate ourselves to doing all four functions in an improved manner, let us be proud that the roots of our entire profession are in psychiatry and that our four basic functions and the way we practice them are our contributions to our total profession. This is important!

It is important for us to recognize that our four basic functions in psychiatry will influence our same four basic functions in the rest of our field of occupational therapy. Our influence will be strong if we consider psychiatric occupational therapy as basic to all occupational therapy and set an example for the rest of our profession by the way we develop and improve our four basic functions. Our influence, however, will be weak if we choose to isolate ourselves from the rest of our profession by considering psychiatry as a special area.

— BARBARA LOCHER, O.T.R.

HIPPOCRATES AND THE OCCUPATIONAL THERAPIST*

The Hippocratic Oath, written by the physician and teacher Hippocrates, embodies the ethical code of the medical world. The elements contained in it have never been changed and are the accepted forms of ethical behavior for all members of the medical team. The main points of the Hippocratic Oath in relation to the ethical practice of the occupational therapist are: that the therapist is dedicated to the preservation of the patient's life; service comes before self-interest; the therapist is dedicated to protect the privacy of the patient, and only those who are primarily concerned with the patient should have revealed to them the intimate details of the patient's case; the therapist is dedicated to make accessible to all people any resources which would improve and treat the patient; and lastly, the therapist is dedicated to the mutual support of his professional organization.

Responsibilities of anyone on the medical team are found within the Hippocratic Oath. These include the student's relation to the teacher, the teacher's relation to the student, the physician's relation to the patient, the physician's relation to other physicians and the physician's relation to the community. The first of these stipulations brought forth in the oath concerns the teacher. This clause implies that nothing should be kept hidden or secret for one's own personal gain; knowledge is to be spread and continued from one generation to another. Also, the teacher may be thought of as the extended arm of the professional organization and the student as an apprentice to this group; therefore the student owes a loyalty and devotion to the professional organization as well as to the teachers who taught him.

The second point brought out is the physician's relation to the patient. It is the duty of each person on the medical team to provide everything that would be most beneficial to the patient and to give nothing to him that would be detrimental or harmful to his person. Also the physician should not take advantage of the patient's weak, defenseless condition. A physician or anyone else on the medical team should practice within the scope of his own knowledge, experience and profession and refer the patient to another person on the medical team when the patient requires the services of that person. Anyone on the medical team is expected to live a good, decent and respectable life, and to live up to the high ethical code of behavior that is expected of him. In conclusion, the six main points included in the Hippocratic Oath and for which occupational therapists are responsible are dedication to: (1) the patient, (2) the physician, (3) the institution which employs him, (4) the community, (5) his department and co-workers, and (6) his professional organization.

— GAYLE CUTLER
(Class of 1963)

*From mid-semester examination, OT Theory I, Indiana University Medical Center, in answer to the question: "Demonstrate how the ethical practice of occupational therapy is derived from the Hippocratic Oath."

A rehabilitation counselor training program, approved by the U. S. Office of Vocational Rehabilitation, is being offered at the University of Pittsburgh, Department of Special Education and Rehabilitation. This program will be offered at the M.Ed., Ed.D., and Ph.D. levels. Candidates may enter the programs in September, January and April of any year. Stipends of $1800, $2000, $2800 and $3400 are awarded by the U. S. Office of Vocational Rehabilitation. For information write Dr. L. Leon Reid, Associate Professor, Department of Special Education and Rehabilitation, University of Pittsburgh, Pittsburgh 13, Pennsylvania.

Picture Page

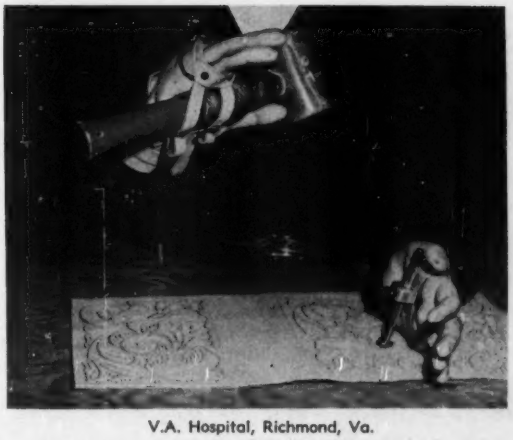
Fitzsimons Army Hosp.

Modified Checkers

Amputee developing skill in using his prosthesis by means of a Chinese checker game. Proprioceptive sense, hand-eye coordination and selection of the proper angle of approach may be developed as well as skill in the use of the elbow and terminal device. The game is graded, in that half of the "men" consist of one to three inch forms of varying weights, textures and shapes. Finer coordination is obtained in handling the second set of "men" which are wing nuts, chap hooks, handles and various small rings and loops. All of the pieces are mounted on three-eighths-inch doweling so that it is necessary to pull each piece out of the hole made with a three-eighths-inch drill, and insert it into the next hole.

Leather Glove Holders

Leather glove holders for a mallet and a metal palm clip which have been used successfully with quadriplegics doing leather stamping. This equipment can also hold other tools where grasp is considerably limited.



V.A. Hospital, Richmond, Va.

Picture Page

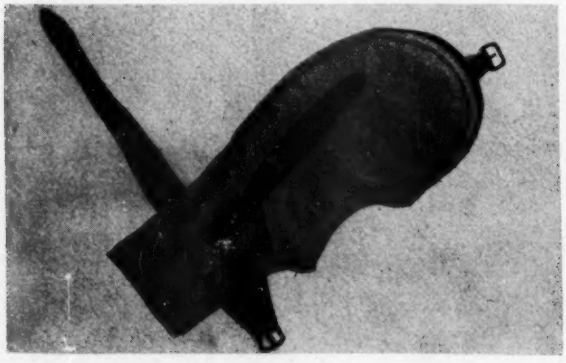
Fitzsimons Army Hosp.

Play Table

This table allows the child to play while being held in the standing position. A series of quarter-inch holes have been made in the table top to allow passage of a cord attached by its upper end to a leather cuff on the child's forearm. The bottom end is tied to a weight just sufficient to control the athetoid movements. The series of holes makes it possible to stabilize either arm in any position. This arrangement also makes it possible to immobilize the non-dominant arm while the patient uses the dominant one.

The table is adjustable for height by means of lifts of various thickness on which the child stands. The top of the table should be sufficiently large to allow for free play, but can be governed by the amount of space in the clinic. The table is forty inches high, so the patient can easily be reached by the therapist. The area where the patient stands should be about six inches wider than the shoulders of the patient. The hinged doors have sliding bolt locks for safety and ease of handling.

Mitten Adaptation



U. S. Public Health Hospital, Seattle, Wash.

A mitten adaptation used for patients with paralysis of the arm and a spastic hand. The mitten is used to strap the hand to the printing press lever. Weights are added as indicated to increase muscle strength.

VERNON L. NICKEL, M.D.

EDWARD STAINBROOK, Ph.D., M.D.

A. JEAN AYRES, O.T.R.

ANNUAL CONFERENCE

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
November 10 to 17, 1960
Hotel Statler
Los Angeles, California

General Theme

REFLECTIONS AND PROJECTIONS*

Conference Highlights

The preliminary program, AJOT and the Newsletter have given you only a hint of what is in store for you in November at the 1960 AOTA conference. The list of speakers has grown and the program promises to be most worthwhile. The first day of the conference will start with an AOTA coffee hour enabling you to meet informally with many of the AOTA officers. Following the keynote speeches by Drs. Nickel and Stainbrook with Evelyn Eichler, O.T.R., and Dale Houston, O.T.R., acting as moderators, will be the grand opening of exhibits —an event which should be attended by all. Papers on current practice have been chosen and will be presented in concurrent sessions—seven papers at a time. These sessions will be repeated so that everyone will have an opportunity to hear two papers. On Thursday Dr. Maxwell Jones, director of research and education, Salem State Hospital, Salem, Oregon, will speak on the "Therapeutic Community." The banquet will conclude the four days of stimulating thinking and active participation on the part of everyone in attendance. Film sessions are planned for 8-9 a.m. every morning.

There are changes in the pre-conference meeting schedule. Monday, November 14th, the history committee meeting has been cancelled. The meeting of respiratory center OT's will be an open meeting. The recruitment and publicity committee meeting has been cancelled. Tuesday, November 15th, the National Recruitment Council meeting with school directors will meet from 7-10 p.m. It is an open meeting with an estimated attendance of 20. Wednesday, November 16th, the National Recruitment Council will meet with state presidents (closed meeting) from 7-10 p.m.

Conference Personalities

Vernon L. Nickel, M.D., is chief of surgical services and head orthopedist at Rancho Los Amigos Hospital, Downey, California, and associate clinical professor of orthopedic surgery, College of Medical Evangelists, Los Angeles.

He received his degree as doctor of medicine from the College of Medical Evangelists and a master of science degree in orthopedic surgery from the University of Tennessee. He has been certified by the American Board of Orthopedic Surgery and is a member of the American Academy of Orthopaedic Surgeons, Western Orthopedic Association as well as national and local medical associations.

Dr. Nickel will participate in the session "Reflections and Projections." He and Dr. Stainbrook will discuss "The Therapist and the Profession."

*For details about the program, refer to the August, 1960, issue, page 227.

Edward Stainbrook, Ph.D., M.D., is professor and chairman of the department of psychiatry at the University of Southern California School of Medicine, and chief psychiatrist at the Los Angeles County General Hospital.

He obtained his doctor of philosophy degree in psychology and doctor of medicine degree from Duke University and was professor and chairman of the department of psychiatry at the State University of New York before moving to California.

Miss Jean Ayres, O.T.R., is consultant to the Marianne Frostig School for Emotionally Disturbed and Brain Injured Children in Los Angeles, and assistant professor and coordinator of the master's degree program in the department of occupational therapy at the University of Southern California.

She received her master of arts degree from the University of Southern California and is working on a doctor of philosophy degree in educational psychology.

She is a member of the Southern California and the American Occupational Therapy Associations, the National Rehabilitation Association and an associate member of the American Psychological Association.

She has been president of the Southern California Occupational Therapy Association, a member and secretary of the graduate study committee and a member of the council on education of the American Occupational Therapy Association. She is a division editor of the *American Journal of Occupational Therapy* to which she has also contributed as an author. She has coauthored *A Manual for Thesis and Directed Research* and prepared a chapter on "Hemiplegia" in *Physician's Occupational Therapy Reference Guide.*

Miss Ayres is a participant of the session on research and will discuss three papers by therapists which will present different approaches to research.

Dr. H. W. Magoun is professor of anatomy in the department of anatomy, School of Medicine, at the University of California at Los Angeles, and is consultant to the Veterans' Administration Hospital in Long Beach, California. He obtained his doctor of philosophy degree from Northwestern University Medical School and taught there until he came to UCLA.

Dr. Magoun is an honorary member of Alpha Omega Alpha, the National Academy of Sciences, and the Societe Francaise de Neurologie. He is an associate member of the American Academy of Neurology and the American Neurological Association.

H. W. MAGOUN, Ph.D.

MARY E. SWITZER

He won the Modern Medicine Award in 1958 from *Modern Medicine* and was given an honorary doctor of science degree from Northwestern University (1959) and Rhode Island University (1960).

Dr. Magoun will speak on sensory motor coordination with reference to cerebral palsy.

Miss Mary E. Switzer has been director of the federal Office of Vocational Rehabilitation since December, 1950. She played a major part developing the Vocational Rehabilitation Act of 1954.

This legislation, enacted unanimously by the Congress, made possible the expansion of the nationwide rehabilitation program and fostered close cooperation among public and voluntary groups toward the goal of providing rehabilitation services to all the nation's disabled citizens.

Miss Switzer has been awarded the President's Certificate of Merit, the highest award given to a regular civil service employee, for her war

work in medical manpower procurement and the development of scientific research programs. In November, 1955, she received the President's Award of the National Rehabilitation Association, and in April, 1956, the U. S. Department of Health, Education, and Welfare presented her with a distinguished service award.

Miss Switzer represented the United States at the first International Health Conference, which developed the constitution of the World Health Organization. She also was a member of the American preparatory commission for the first World Congress on Mental Health and of the U. S. delegation to the congress in London in 1948.

Miss Switzer is a graduate of Radcliffe College and an honorary member of Phi Beta Kappa and has been elected to the board of trustees of the college. She holds the honorary degree of doctor of humane letters from both Tufts University in Massachusetts and Gallaudet College in the District of Columbia, and doctor of laws from Adelphia College. Just recently she received the honorary degree of doctor of humanities from Boston University, and the Woman's Medical College of Pennsylvania bestowed upon her the honorary degree of doctor of medical sciences.

Miss Switzer is a trustee of the Menninger Foundation, first vice-president of the American Hearing Society, member of the board of directors of the Alexandria Hospital in Virginia, board of directors of the Association for Aid to Crippled Children, and the steering committee of the first World Mental Health Year. She is on committees of the National Foundation and the International Society for the Welfare of Cripples. She is an advisory fellow of the World Federation of Occupational Therapists. She is president-elect of the National Rehabilitation Association.

At the conference Miss Switzer will discuss the future of rehabilitation.

RESEARCH REPORTS

REHABILITATION LITERATURE, published by the National Society for Crippled Children and Adults, is interested in publishing brief reports of research studies that its readers will find significant and interesting. The report should describe briefly the procedures for the study and give an account of the findings.

For the report to be printed as a one-page article, it should be 750-1000 words in length. The manuscript should be typed double spaced. The editor asks that the report be accompanied by information that will identify the author and the research project. Information needed includes the author's professional qualifications, his relationship to the project, and information as to sponsorship and support, if any, of the research project. If the brief report is a condensation or summary of a more extended report, a copy of the full report should be submitted for the editorial files of REHABILITATION LITERATURE.

GRADUATE STUDY GRANTS

The committee on graduate study accepted the responsibility for the administration of the $30,088 grant offered by the Office of Vocational Rehabilitation for graduate study related to occupational therapy. The grant included monies for three doctoral level and eight master's degree level traineeships. A total of sixty-eight application forms were sent out of which twenty-six completed forms were returned. Four of these were for the doctoral level of advanced study.

A selection subcommittee of the committee on graduate study met in Madison, Wisconsin, on June 21, 1960, to review information obtained on each applicant and the following individuals were awarded the traineeships.

Marguerite Abbott, O.T.R.: first year doctoral level, amount $2800 for the academic year 1960-1961 at Columbia University.

Miss Abbott received a diploma from the Boston School of Occupational Therapy, a bachelor of science degree from Tufts University, and her master's degree in education from Columbia University. Professionally and briefly Miss Abbott has held appointments as a member of the occupational therapy staff of the faculty of medicine, Columbia University, continuously from 1944-1959. During this time she served on a full or part time basis in the various capacities of instructor, associate director, acting director, and assistant professor of occupational therapy.

Miss Abbott has also served overseas, particularly in Scotland, by invitation, as visiting American professor in occupational therapy at the Astley-Ainslie School of Occupational Therapy in Edinburgh. At this time she gave post-graduate courses to the Astley-Ainslie teaching staff, and hospital directors, in supervision of students and clinical teaching.

In 1959 she assumed the responsibility as director of the American Occupational Therapy Association curriculum study project. In addition to this, Miss Abbott has been a professional writer in the field of occupational therapy with twenty-five publications to her credit. Miss Abbott states that her main objective in obtaining a doctor of education degree, is to prepare herself as a curriculum specialist in teaching methods.

Janet Anderson, O.T.R.: master's degree level, amount $2400 for the academic year 1960-1961 at the University of Chicago.

Miss Anderson is a graduate from Milwaukee-Downer College and has been employed by Michael Reese Hospital-Medical Center in Chicago. Her chosen field of study is human development which she hopes to utilize in furthering the "basic approach" to education of occupational therapy students.

Velda Brust, O.T.R.: master's degree level, amount $2,400 for the academic year 1960-1961 at Oregon State College at Corvallis, Oregon.

Miss Brust received her bachelor of science degree in physical education from Oregon State College and a certificate in occupational therapy from the University of Southern California. She was employed by the Oregon Society for Crippled Children before accepting a position as an assistant professor and an assistant director of occupational therapy at the College of Puget Sound,

Tacoma, Washington. She has been granted a leave of absence from her position there, and anticipates returning to the teaching field.

Catherine Hoffman, O.T.R.: master's degree level, amount $2,400 for the academic year 1960-1961 at the University of Connecticut at Storrs, Connecticut.

Miss Hoffman was graduated from Northern Illinois University at Dekalb, Illinois, with a major in home economics. After teaching home economics in high school she attended Western Michigan University to obtain her occupational therapy diploma. Since that time she has been employed at Winfield Hospital, Winfield, Illinois; first as assistant occupational therapist, later as director of occupational therapy. Miss Hoffman will be the first graduate student to enter the field of vocational rehabilitation training for the disabled homemaker at the University of Connecticut.

Lelia Jaffe, O.T.R.: second year doctoral level, amount $3,200 for the academic year 1960-1961 at Columbia University.

Miss Jaffe received her bachelor of arts degree at Western Reserve University with a major in fine arts. Her occupational therapy certificate was received from the College of Physicians and Surgeons at Columbia University. Subsequently she received her master of arts degree from Teachers College at the same university.

During a two-year tour of active duty with the Medical Specialists Corps of the U. S. Army, she served at Walter Reed, Fitzsimons and Brooke Army Hospitals. Miss Jaffe then spent two years at Western Reserve University Hospital in Cleveland as supervisor of the ward occupational therapy program.

When Miss Jaffe returned to New York to pursue her graduate studies, she first served as a staff therapist at the Hospital of the Rockefeller Institute of Medical Research, then as director of the volunteer training and placement for the Handicapped Children's Home Service. For the last five years, Miss Jaffe has been director of the occupational therapy department at Beth Abraham Home in the Bronx, New York.

She hopes to use her training as an instructor of rehabilitation at the university level and as an administrator of rehabilitation facilities.

Jerry Johnson, O.T.R.: master's degree level for the academic year 1960-1961, amount $2,400 at Harvard Graduate School of Business Administration.

Miss Johnson is a graduate in occupational therapy of Texas Woman's University, Denton, Texas. She has completed one year of a two year course at Harvard leading to a master's degree in business administration. Professionally she has been an occupational therapist in the Navy and later the youngest executive director in the Illinois Society for Crippled Children and Adults. She hopes to use her training in the administration of rehabilitation service.

Catherine MacDonald, O.T.R.: master's degree level, amount $2,400 for the academic year 1960-1961 at Western Michigan University.

A graduate of Western Michigan University in occupational therapy, Miss MacDonald will study supervision and administration of occupational therapy on the graduate level there.

She has been a director of occupational therapy at St. John's Hospital, student instructor at Northville State Hospital and supervisor of industrial placement and vocational guidance at Kalamazoo State Hospital.

Susan Mahan, O.T.R.: master's degree level, amount $2,400 for the academic year 1960-1961 at Western Reserve University in Cleveland, Ohio.

Mrs. Mahan is a graduate in business administration from the University of Minnesota. She attended the Richmond Professional Institute and received her certificate in occupational therapy there.

She has had a varied employment history in business and secretarial work. Professionally as an occupational therapist she was employed by the Army, and by the Veterans' Administration in various locations and has taught occupational therapy at the University of Minnesota. She has been the chief of occupational therapy at Highland View Hospital in Cleveland since 1956. This hospital is known for its progressive dynamic program and Mrs. Mahan is returning to school to keep abreast of the ever expanding program there. Mrs. Mahan has two children ages six and twelve.

Diane Peters, O.T.R.: master's degree level, amount $2,400 for the academic year 1960-1961 at the University of Southern California.

Miss Peters has recently been released from duty with the U. S. Air Force. She had been stationed at Lackland Air Force Base in Texas and in England, where she set up an occupational therapy department in one of the Air Force hospitals.

A graduate of Mills College, where she received a bachelor's degree in occupational therapy, Miss Peters will complete the course in occupational therapy at the University of Southern California, which she hopes will prepare her for an administrative position or teaching.

Mildred Sleeper, O.T.R.: master's degree level, amount $2,400 for the academic year 1960-1961 at the University of Southern California.

Miss Sleeper received a certificate in occupational therapy from the Boston School of Occupational Therapy and a bachelor of science degree in occupational therapy from the University of New Hampshire, and besides this professional training she has completed the Warm Springs graduate course, the cerebral palsy course at Reisterstown, Maryland. She did graduate work at the University of Connecticut in the area of rehabilitation of the disabled homemaker, the rehabilitation of physical disabilities at New York University and the course in organization and administration for occupational therapy at the University of Pennsylvania. Miss Sleeper will utilize her advanced study in training students at either the academic or clinical levels.

Adelaide Smith, O.T.R.: master's degree level, amount $600 (for one semester only) at the University of Southern California.

Mrs. Smith has received her bachelor's degree and certificate in occupational therapy from the University of Wisconsin and has completed all but one semester of her master's work at the University of Southern California.

She has been an occupational therapist in the Army and since her discharge has been working with the Arizona Society for Crippled Children and Adults in various capacities. At present she is director of vocational services at Homecrafters, Inc., where she coordinates all the vocational planning in the center. She plans to return to the Homecrafters to expand the program there.

Ruth Whipple, O.T.R.: first year doctoral level, amount $2,800 for the academic year 1960-1961 at Western Michigan University.

Miss Whipple received her bachelor of science and

master's degree in occupational therapy from Western Michigan University.

Professionally Miss Whipple has been working in the educational field of occupational therapy and has been granted a leave of absence from her position as assistant professor at Texas Woman's University at Denton, Texas. Miss Whipple anticipates that her advanced study will prepare her for occupational therapy school administration.

Letters

To the Editor:

In regard to the article, "Planning Occupational Therapy for Schizophrenic Children" by Irene C. Rousos, O.T.R., in the May-June issue of AJOT, there are many points with which we would like to disagree.

1. The article states, "Good play activities allow them [children] to release tension and aggression and other emotions in an acceptable manner." How can children release tension and aggression when, in the next few paragraphs the author states, "the child is never given a ball of clay and left to do what he will—it may be helpful to show him some animals or small bowls already formed and say, 'Let's make an animal like this one'." Another example of this is found in the very next paragraph in which the author tells that activities such as fingerpainting are *governed by the therapist.* What is she afraid of? It appears that the child is merely duplicating someone else's expression and keeping his own within. How can the psychotic child be expected to become "normal" if the bizarre feelings are not released? By keeping them within himself at this time a reoccurrence of his psychosis seems inevitable at some future time.

2. Why insist that the child control his impulses at this point? Why not allow him to show his aggressive impulses and *then* help him to channel them into socially acceptable activities? It seems that this therapist wants the child to have acceptable impulses *during* therapy rather than as a *result* of therapy.

3. The satisfaction that the child could receive from the product is given to the therapist who governed the activity.

4. And, last, the article states that "greater opportunity is afforded for the insecure child to develop cooperativeness as well as initiative and independence." In no part of this article can it be shown that the child has any opportunity to develop initiative or independence as there is someone directing him every step of the way.

We were also surprised to find that although this article stated definite approaches to the treatment of the schizophrenic child there were no references to psychiatric or psychological literature.

We would be very interested to hear the author's defense of her article.

Sincerely,
Sue Kaplan, O.T.R.
Elaine Bikofsky, O.T.R.

The third world congress on psychiatry will be held for the first time on the American Continent when it meets June 4-10, 1961, in Montreal, Canada, under the auspices of the Canadian Psychiatric Association and at the invitation of McGill University.

For a copy of the program, write the General Secretary, III World Congress on Psychiatry, 1025 Pine Avenue West, Montreal 2, PQ, Canada.

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Minnesota—Dortha Esch, O.T.R.
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New Jersey State Hospital
Trenton, New Jersey

Members

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Box 65, U. of Florida Teaching Hospital
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Delegates Division

ILLINOIS

Delegate-Reporter, Fred Sammons, O.T.R.

The Illinois Occupational Therapy Association has had a busy year with the 1959 conference being our main focus. Nearly every therapist in the state had an active part in making the conference a success. This tremendous project makes the affairs of the state association almost an anti-climax but we are again vigorously pursuing local interests.

Our January meeting considered the Montessori method which involves giving children freedom of expression through special materials to accelerate the learning process. In February we were enlightened on recent developments in cardiac vascular surgery. Professional liability insurance was our topic in March. The American Hospital Association provided us with an informed staff member whose first effort was to substitute the more correct term of professional liability insurance for the word malpractice.

Therapists from several hospitals and agencies revealed the coverage or lack of coverage provided their staff members. Since many agencies provide coverage, the demand by the individual therapist was limited. A joint occupational therapy-physical therapy meeting was held in April. Dr. Frederick E. Vultee discussed disaster planning. The place of the therapist in a major disaster was vividly described. The annual tri-state hospital assembly, held in Chicago during May, afforded us an opportunity to work with our neighboring states in planning a program of interest to the occupational therapist. Meetings were held jointly with the physical therapy section. The morning session considered "Outlets for Aggression." The afternoon session studied "Hand Rehabilitation" from the standpoint of treatment and research.

Intensive recruiting on a state-wide basis is becoming a reality. The Illinois Hospital Association has invited our association to be one of the nine paramedical services participating in this effort. The IHA will initially provide guidance, staff and funds with the understanding that the project will develop into a functioning organization. The recruiting organization will have a budget, office staff and a board of directors composed of representatives of the nine groups and other resource persons. If successful this could provide an easily duplicated structure for state-wide recruiting.

OFFICERS

President .....Mary Frances Heermans, O.T.R.
Vice-President .....Nedra Gillette, O.T.R.
Secretary .....Ellen Harenburg, O.T.R.
Treasurer .....Michaela Apfeld, O.T.R.
Delegate .....Fred Sammons, O.T.R.
Alternate delegate .....Mary Anne Anderson, O.T.R.

MICHIGAN

Delegate-Reporter, Marjorie Holtom, O.T.R.

If Michigan were to select a theme for its meetings during the past year it might be entitled, "The Professional Responsibilities of an Organization." In September we joined forces with the Michigan Physical Therapy Association for a meeting entitled, "The Role of Physical and Occupational Therapists in Disaster Planning." This meeting was held at the national civil defense headquarters at Battle Creek. Stimulated by this timely subject several district meetings probed further into the responsibilities of occupational therapy in a national disaster.

The annual meeting of the Michigan Occupational Therapy Association was held at the Children's Psychiatric Hospital, University Medical Center at Ann Arbor, on May 7. Our topic was professional development and our guests were Miss Wilma West and Miss Marjorie Fish. Actually, we have been fortunate to be able to discuss national problems on a rather informal basis for as Miss Fish remarked, "Practically every person from the national office has visited Michigan this year." In March of 1959 an item writing workshop brought Miss Schwagmeyer and Dr. Brandt. Early in the fall Carlotta Welles appeared as a member of the curriculum study project. She was followed by Marguerite Abbott and Mary Booth who visited our three occupational therapy schools. In April Miss Hollis helped solve some of our rehabilitation problems.

In addition to the visitors from our national office we have promoted our professional theme by continuing membership in the Michigan Health Council; by cosponsoring a program on "The Role of Occupational Therapists in Geriatric and Chronic Disease Problems"; by serving on the planning committee for a physical therapy-occupational therapy workshop; and by cosponsoring with the University of Michigan, Division of Gerontology, the twelfth annual conference on aging.

Our biggest professional challenge continues to be in the area of membership. If we could interest all potential members in active membership we would win a victory of sizeable proportions.

Throughout the year various committees of the Michigan Occupational Therapy Association have been busy. A committee published four issues of the MOTA *BULLETIN* which was sent to every occupational therapist in the state. In an effort to raise money for scholarship assistance for needy students, the finance committee has been selling small loose-leaf notebooks and a used-book sale is being planned. The special studies committee is busy preparing a booklet of medical abbreviations which is scheduled to be ready for the 1961 AOTA conference in Detroit. A second project of this committee is a cartoon contest for a new recruitment brochure to interest junior high school students in occupational therapy as a profession.

The recruitment and publicity committee participated in four regional conferences sponsored by the Michigan Health Council. They prepared and manned an exhibit on occupational therapy at the Michigan state fair, and they have provided therapists for career day programs in various schools throughout the state.

Ere long we hope to have a booklet containing the history of occupational therapy in Michigan. Miss Spear has been gathering material for the past two or three years.

Our civil defense committee mailed packets of disaster planning literature to all other civil defense committees of state occupational therapy associations. A newly formed committee on geriatric and chronic disease problems has been appointed to investigate the role of occupational therapy in these programs.

Perhaps the highlight of the past year has been the presentation of honorary awards to Miss Marion R. Spear, Mrs. Arshalous Kasabach, and to Miss Christine Newman. Each of these therapists has contributed long and sincerely to the advancement of occupational therapy in Michigan.

OFFICERS

President ..... Lyla Spelbring, O.T.R.
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Treasurer ..... Dorothy Kiger, O.T.R.
Delegate ..... Marjorie Holtom, O.T.R.
Alternate delegate ..... Dean Tyndall, O.T.R.

NEW JERSEY

Alternate Delegate-Reporter, Lucille Boss, O.T.R.

Among other aims, the New Jersey Occupational Therapy Association has endeavored during the 1959-1960 season to inform the general membership more fully regarding the affairs of our professional organizations and to involve them more actively in carrying out our various professional obligations.

A buffet supper in June, 1959, at which a number of occupational therapy students affiliating in New Jersey from various schools were our guests, featured a report on the special meeting of the House of Delegates held in Indianapolis and was followed by a lively discussion. We were privileged in October to have Dr. Nolan D. C. Lewis discuss "Symbolism" with us, which he illustrated with fascinating examples of art work created by his patients over a period of time.

At our November meeting the delegate's report of the conference held in Chicago was the principal concern. This was followed by a tour of the facilities of the rehabilitation unit of the Essex County Hospital at Belleville, our host. A "Jersey Jam Session" in March consisted of a frank discussion and evaluation of the structure and function of both our state and national associations by a representative group of the membership. In April the annual meeting was held at the new Hunterdon Medical Center in Flemington. Dr. Robert Henderson, medical director, described the "Philosophy and Development of a Rural Medical Center" and volunteers showed us about their modern hospital.

We were represented at the eastern regional recruitment workshop at the University of Florida at Gainesville by our president, Fred Odhner. Percy Clark prepared and presented an outline of the needs in the field of occupational therapy in New Jersey at a public hearing on the Independent Living Bill held in Jersey City in February. Clive Krygar representing occupational therapy met with other disciplines involved with the arthritic planning project conducted under the auspices of the New Jersey Department of Health, Division of Chronic Disease Control. Miss Ethel Huebner has continued this past year as speaker of the House of Delegates of the American Occupational Therapy Association.

OFFICERS

President ..... Fred Odhner, O.T.R.
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Delegate ..... Ethel Huebner, O.T.R.
Alternate delegate ..... Lucille Boss, O.T.R.

UTAH

Delegate-Reporter, Janet Richardson, O.T.R.

The ever present problem of a scarcity of members had a new twist for the Utah Occupational Therapy Association. In spite of the fact that the association has only 18 active members, it had three presidents and of course an equal number of vice-presidents. For a while it looked like the constitution would have to be changed to allow for the appointment of president on an alphabetical basis instead of by election.

Participation in meetings has been increased by interesting speakers and a picnic instead of summer meetings. The annual picnic this year was held in pouring rain. It was a gay time as we welcomed the families of new members. Although the spirits of some of the children were slightly dampened, the members have voted to have another picnic next year and try for better weather.

Much time and energy were expended in the second annual western regional recruitment workshop. This project has given the members some valuable experience in organization and cooperation. It is hoped that this will carry over into the association's ever present and most pressing recruitment and publicity problems and the current project of favors for the school luncheon at the national convention in Los Angeles.

OFFICERS

President ..... Betty L. White, O.T.R.
Vice-President ..... Betty Pflueger, O.T.R.
Secretary ..... Russell Mosier, O.T.R.
Treasurer ..... Winifred Corey, O.T.R.
Delegate ..... Janet Richardson, O.T.R.
Alternate delegate ..... Jean Korner, O.T.R.

NEW COURSES

The Division of Physical Therapy and the Philadelphia School of Occupational Therapy of the School of Allied Medical Professions of the University of Pennsylvania are offering the following special courses during 1960-61:

Neurophysiological Bases for Rehabilitation—January 16-27, 1961. An understanding of the principles underlying the current neuromuscular approaches to treatment is based on a deeper knowledge of the function of the integrated nervous system. In addition to lectures in neurophysiology, neuroanatomy and clinical neurology the course content will include the following: methods of patient evaluation, discussion of treatment concepts, demonstrations of various treatment techniques, seminars and panel discussions.

Growth and Development—February 13-17, 1961. The physical, physiological, neurological and motor patterns of growth in the human being are traced from their inception in the embryo through the geriatric years. Each significant growth stage is analyzed and standards for normal are identified so that deviations may be recognized and classified.

Arch of Development—Childhood and the Aging—February 20-24, 1961. This course is designed to provide occupational therapists with a background which will enable them to deal more effectively with emotionally disturbed patients. The psychological development of the individual from childhood through the aging years is discussed and the psychiatric aspects are examined in relation to the normal. In addition to lectures there will be case presentations and clinical observations.

These courses are open to graduate occupational and physical therapists. The fees are as follows: $25.00 for the two-week course and $12.50 for the one-week courses. They are being sponsored by a grant from the United States Office of Vocational Rehabilitation and a limited number of traineeships are available. Inquiries should be forwarded to:

Miss Roslyn Schlansky, Coordinator
School of Allied Medical Professions
University of Pennsylvania
3901 Pine Street
Philadelphia, Pennsylvania

Reviews

ROLE OF INTENSIVE PHYSICAL AND OCCUPATIONAL THERAPY IN THE TREATMENT OF CEREBRAL PALSY: TESTING AND RESULTS.

Alvin J. Ingram, M.D., Elizabeth Withers, M.S., O.T.R., Elizabeth Speltz, R.N., R.P.T. *Archives of Physical Medicine and Rehabilitation*, Vol. 40, October, 1959.

This article deals with the results of 60 cerebral palsied children selected for admission to the Crippled Children's Hospital School in Memphis, Tennessee, who were subjected to intensive programs of occupational and physical therapy and whose progress was tested before and after on a developmental scale of motor and social performance.

The test, devised in 1951, with the consultation of such notable authorities as Gesell, Ilg, Zuck, Johnson, and Wingate, is based primarily on Gesell's developmental schedules. Both a motor age and a social age can be determined. "The motor age represents the basic motor skills of the upper and lower extremities, for example the ability to walk, and is roughly the province of physical therapy. The social age indicates the ability to operate in society and perform the necessary acts, and is the province of occupational therapy."

The purpose of the test is to measure progress objectively, help determine which patients can be selected most profitably for admission to the Children's Hospital School in Memphis, as well as, in certain instances, suggest treatment programs.

Of the 60 children in this study, 40 or two-thirds experienced improvement. It was further determined that youngsters below a certain initial score made no progress. Other important correlations relating to age, diagnosis, convulsive status, encephalographic findings and intelligence quotients were made. Average hospital stay for all three groups—not improved, not significantly improved, and improved—was 12 months.

The advantages and disadvantages of the test are aptly pointed out in the article. One of the advantages dealt with utilizing the scale as a tool to help determine surgical correction of certain hip deformities. In as much as none of the children in the study were over nine years of age, abductor transfer, obturator neurectomies, abductor tenotomies and hip releases mentioned in the article would certainly be considered only after much more extensive workup.

The article fails to reveal the "intensive occupational and physical therapy" administered to the 60 cerebral palsied children. Therefore, it is difficult to determine what caused two-thirds of the youngsters to "improve." The article also fails to reveal control groups used on the scale with no treatment or other forms of treatment. The scale has merit in establishing motor and social age, but utilized for the purposes suggested by the authors is open to justifiable criticism.

A child may rate perfect (5 year zone) on the test. That is, the child is able to accomplish all the test activities to the satisfaction of the tester. Yet, the child still walks in knee flexion, plantar flexion, adduction and inward rotation. The test seems of little value for cases like this. Goals for the cerebral palsied are important considerations when measuring progress and determining who should or should not receive treatment. A treatment center must decide on philosophy before "going into business." One might seek "normalcy" for every patient admitted, and consequently admits on this basis. Another may be satisfied with teaching and training a youngster only up to his physical, emotional, social, and intellectual capacity, even if that capacity is no more than a 3-year-level.

The testing device in this article is a step in the right direction, but before it is used as the writers imply, it needs much more serious study.

—Lester M. Brower, M.A., O.T.R., R.P.T.

COMMUNICATING WITH SCHIZOPHRENIC PATIENTS. Alice M. Robinson. *The American Journal of Nursing*, 60:8 (August) 1960, pp. 1120.

The author observed that a schizophrenic patient may not be so much lonely and lacking in love as that he is really a "masochistically powerful person who 'keeps everyone at bay' neatly, and by a number of defensive mechanisms." He prefers and keeps his relations with others the way he wants them to be.

Uncomplicated love and a tolerent understanding of the patient can establish a rapport which enables the patient to trust the nurse. When this empathy is established, work with the patient becomes therapeutic.

FREUD AND DEWEY ON THE NATURE OF MAN. Morton Levitt. New York: Philosophical Library, 1960, 180 pp., $3.75.

As far as is known, these two world-renowned intellectual giants never met nor indicated any acquaintance with each other's ideologies. Yet there are pertinent instances where certain concepts expounded by the educator line up closely with those of the psychoanalyst, i.e., Dewey's interpretation of thinking "as a dynamic process by which the individual explores and comes to terms with the world," and Freudian theory pertaining to "recognition of cognitive functioning in the human personality."

The author has presented interesting facts regarding parallel circumstances in the biographical background of the two scholars, in the intellectual influences upon their training, and in their contributions to social science. Dewey attacked traditional philosophy; Freud opposed descriptive psychiatry.

The sharp contrasts in their theories are also revealing. "Dewey's social psychology emphasized the contemporaneous and he even seemed to be prepared, on occasion, to account for the past in terms of the present. Freud, contrariwise, viewed the present through the past." Freud accentuated the "individual" factor in the study of "individual-interaction-environment," whereas Dewey's emphasis was "environmental." Freud turns more and more "within," and Dewey faces more and more "without." Their contributions to the study of human behavior have been profound and far-reaching, yet "both were bitterly opposed by theological groups, academic disciplines, and by much of the public."

—Bertha J. Piper, O.T.R.

BULLETIN OF THE MENNINGER CLINIC, 24.3 (May) 1960.

The articles included in this issue are part of a research project studying "Methods of Coping With Stress in the Development of Normal Children." The project is supported by a grant from the Public Health Service of the United States Department of Health, Education and Welfare. The group was composed of normal children of pre-school age. These were the same children studied earlier which formed the basis for the material in *Prediction and Outcome: A study in Child Development* by Escolona and Heider and published by Basic Books. A review of this book is included in the back section of the Bulletin.

The articles present ways normal children cope with stress or tension, and how they utilize resources in meeting challenges and problems at each developmental stage.

The variance in this group of normal children was marked but all remained within the normal range. "High intelligence as measured by tests did not necessarily and automatically lead to effective coping. On the other hand, certain cognitive functions, such as perceptual clarity, contributed greatly to some aspects of coping, such as resilience following stress or capacity to mobilize energy under stress. Good memory seemed to be a definite asset, especially for boys. Interestingly enough, general intelligence as measured by tests seemed to play a larger role in maintaining inner integration . . . than it did with handling the external environment . . ."

GRADUATE STUDY—A KEY TO PROFESSIONAL DEVELOPMENT. F. A. Hellebrandt, M.D. *The Physical Therapy Review*, 40:4 (April) 1960.

A research program carried on by the faculty of a school offering graduate study in physical therapy provides a stimulating atmosphere for the student. A research program effects good habits of thinking, discrimination and judging. Results would favorably influence both clinical practice and teaching at the undergraduate level.

Suggested research programs could include educational, psychological and sociological research and better research in the scientific foundations of the profession.

"Research has only one purpose, and that is to add to human knowledge. To communicate that which has been learned through original study is one of the obligations of the researcher. Thus writing cannot be separated from research. It is an integral part of the research process and one of the important technics learned by all who spend any appreciable amount of time in the contemplation of bodies of evidence which enhance understanding. For many, writing is the most difficult of all the steps which comprise research. Few investigators enjoy this aspect to research, but all serious students accept the responsibility of communicating the results of their investigative effort."

CATES' PRIMARY ANATOMY. J. V. Basmajian, M.D. Baltimore: The Williams and Wilkins Co., 1960, $6.50.

The author questions whether or not a good elementary course for "nurses, physiotherapists, occupational therapists, health and physical educationalists, and the like ever-increasing army" should emphasize only these phenomena that elucidate the elementary gross anatomy. With this premise in mind he has written this book for "non-medical students." The skeletal, articular muscular and circulatory systems have been treated in greater detail than the digestive, respiratory, urinary and generative. Because of the importance of the nervous system in regulating the activities of all others it has been treated in great detail. Simple schematic illustrations showing the attachments and actions of muscles are treated singly as these have proved so basic over the years the author was a teacher. He uses the heavy type method to draw attention to paragraphs and key words. The laboratory work for the student using this book would be with already dissected specimens. Somehow I feel that this is all too simple and I prefer the method of learning in which the student does his or her own dissection. This text book seems better for training OT aides or for review work with advanced standing students.

—RUTH L. MELSHEIMER, O.T.R.

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum ad $4.00 *for* 3 *lines, each additional line* $1.00. (*Average* 56 *spaces per line.*) *Classified display, boxed,* $5.00 *per column inch. Copy deadline first of each month previous to publication.*

POSITIONS AVAILABLE

Available about September first: Position for occupational therapist in new day hospital program of general hospital psychiatric service. This is a small unit with an active program planned. Minimum $4600—higher with experience. Also, immediate opening for occupational therapist on GM&S service in physical medicine department. Paid Blue Cross, insurance, 3 week vacation, sick leave, and holidays. Contact: Miss Louise A. Rathbone, Chief OT, The Roosevelt Hospital, W. 59th St., New York, N.Y.

Wanted: registered occupational therapist to head department, 60 bed hospital for NP services. Salary open —5 day week. Paid vacation, sick leave, legal holidays, group hospital and life insurance. Apply Peachtree Hospital, 41 Peachtree Place, N.E., Atlanta 9, Georgia, giving qualifications and experience.

Opportunities for professional growth and advancement with excellent medical supervision in adult and child psychiatry programs—in-service training, participation in team conferences. OT student affiliation center. Openings for staff OT and supervisor of OT in expanding program of modern 225-bed acute, intensive treatment, research and teaching psychiatric hospital, located on campus and affiliated with Indiana University Medical Center. Swimming pool, tennis courts and recreational facilities on campus. Excellent salary, holiday, leave and retirement plans. Blue Cross-Blue Shield available. Initiative and resourcefulness considered for inexperienced therapist, registered or eligible for registration. Additional consideration given therapist with acceptable professional experience. Contact: Virginia L. Caskey, O.T.R., Coordinator of Activity Therapy, Larue D. Carter Memorial Hospital, Indianapolis 7, Indiana.

Large, progressive teaching institution in Cleveland, Ohio, offers a challenging staff position with 5 day, 40 hour week, exceptional benefits, modern facilities, and competitive salary. Reply Box 90, American Journal of Occupational Therapy, 3514 N. Oakland Ave., Milwaukee, Wis.

Wanted: Registered occupational therapist II (director), salary $4,680 to $5,824. Occupational Therapist I, salary $3,900 to $4,888 depending on qualifications. Relatively new department with growth possibilities. Paid vacation, sick leave, legal holidays, excellent retirement system, group life insurance. Apply: Peter W. Bowman, M.D., Supt. Pineland Hosp. & Training Center, Box C, Pownal, Maine.

Occupational therapist registered: 2 vacancies at Grasslands Hospital—one psychiatry, one geriatrics and medical services. Beginning salary $4710 with annual merit increases to $5290. Liberal personnel policies. Apply Personnel Office, Grasslands Hospital, LY-2-8500, Ext. 61. Valhalla, N. Y.

Immediate opening for OTR to be director of OT dept. in 230 bed intensive treatment state psych. hosp. New air conditioned bldg., new equip., 40 hr. week, civil service, starting salaries of $400 & $315 respectively, with annual increases. Total therapy program with team approach. Teaching and research opportunities. Male or female therapists, US citizenship required. Contact Supt., Woodside Rec. Hosp., Youngstown, Ohio.

Staff position for registered occupational therapist or eligible graduate, rehabilitation dept. of large, modern tuberculosis hospital. Pleasant suburban location with good transportation, shopping and recreational facilities. 40 hour week, paid vacation and holidays, liberal cumulative sick leave, retirement plan. Full maintenance available at reasonable rate. Opportunities for further education in local universities. Write: Director of Rehabilitation, Sunny Acres Hospital, Cleveland 22, Ohio.

Immediate placement: male or female staff occupational therapist (registered or eligible for registration) opportunities in psychiatric and rehabilitation areas working in conjunction with physical therapy. 300 bed J.C.A.H. general hospital completely new modern and excellent facilities, 40 hour work week, good working conditions and liberal personnel policies. Salary commensurate with experience. Apply Personnel Department, Saint Joseph's Hospital, South Bend, Indiana.

Conn. state chronic disease hospital. Two OTR positions immediately available in 275-bed hospital in Hartford vicinity. Living quarters available. Civil service benefits. Salary range $3840-$4740. Contact Supt., Cedarcrest Hospital, Newington 11, Conn.

Immediate openings—registered occupational therapists. Large PM&R service with active supervision and guidance of psychiatrist. Clinical training program. 2400 bed psychiatric hospital. Career positions with opportunities for advancement. Attractive fringe benefits. Starting salary—six months experience or graduation in upper 25% of class—$4980. Starting salary—no experience—$4040. Write: Personnel Officer, VA Hospital, Northport, L.I., New York.

Positions open for staff therapists in progressive well-equipped OT department of largest private mental hospital (750 beds) in USA. Well-rounded program includes both workshop and ward classes. Paid annual vacation and sick leave, laundry and maintenance provided. Pleasant working conditions, beautiful surroundings. Write to Dr. J. Butler Tompkins, Superintendent, Brattleboro Retreat, Brattleboro, Vt.

Positions available: Supervisor requiring registration and at least two years experience. Staff therapist requiring registration or registration eligibility. These positions are now open in an accredited dynamically oriented psychiatric teaching hospital offering opportunities to do research, teaching and to work with other disciplines in treating the acute emotionally sick, ages 12 to 60, within a three hundred bed hospital. For further information contact Miss Inez Huntting, O.T.R., Director Occupational Therapy, Cleveland Psychiatric Institute and Hospital, 1708 Aiken Avenue, Cleveland 9, Ohio.

Staff OT positions in new, modern, 1100 bed GM&S hospital with TB allocation, affiliated with N. Y. Medical College. Large, well equipped dept. with immediate placement in areas of physical disabilities and pulmonary disease. Seven hour day, five day week, four weeks paid vacation, eleven holidays, twelve days sick benefits, shorter summer hours. Salary $4250 per annum. Write: Miss E. A. Palmer, O.T.R., Metropolitan Hospital, 1901 First Ave., New York 29, N.Y.

OCCUPATIONAL THERAPISTS for California's progressive programs in state mental hospitals and for physically handicapped children in special schools. Opportunities for imaginative and resourceful therapeutic activities. Eligibility for registration with the national registry of the American Occupational Therapy Association is required. No experience is needed to start at $436 a month. Positions in schools under the Crippled Children Services program are open also to experienced occupational therapists at $481 a month. Attractive employee benefits. Secure details from State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

Co-ordinator of activity therapy—Salary range: $525 to $625 per month. Minimum requirements: graduation from an approved school of OT, registration, and five years experience in psychiatric occupational therapy, of which two years should have been in a supervisory capacity and one year in an administrative capacity, such as supervisor or director of a psychiatric OT program. Full maintenance including apartment and commissary privileges available. Apply: Ralph B. Cary, Personnel Officer, Logansport State Hospital, Logansport, Indiana.

Occupational Therapist I: occupational therapist position for a male at the institution for the mentally ill. Requires graduation from a school of occupational therapy approved by the Council of Medical Education and Hospitals of the American Medical Association including or supplemented by one year of supervised occupational therapy work experience in a recognized agency or institution. Salary $403.00 per month. Apply: Mrs. Loretta Fukuda, Recruiting & Examining Supervisor, Hawaii Personnel Services, 825 Mililani St., Honolulu 13, Hawaii.

A few staff therapists positions are still open for a chronic disease (all ages) and geriatric program in a 2000 bed city hospital and home affiliated with New York Medical College. Positions are available in children's rehabilitation (cerebral palsy), adult rehabilitation, hospital-home maintenance program, home care and special studies. Student training program. Seven hour day, five day week, four weeks paid vacation, eleven holidays, twelve days sick benefit, six hour day for summer months. Salary $4250-$5330, (annual increments $180). Write Mrs. Carolyn Aggarwal, O.T.R., Bird S. Coler Hospital and Home, Welfare Island, New York 17, New York.

Immediate opening for male OTR to head the activity therapy department in large state hospital. Large department with emphasis on industrial activities. Other sections within the department include occupational therapy, recreation, education, volunteer services and audio-visuals. Hospital is growing with many new buildings and programs. Liberal personnel policies. Three years experience with one year supervisory level required. Salary range from $5400 to $6720 per year. Write Theodore G. Denton, M.D., Superintendent, Central State Hospital, Petersburg, Virginia.

Occupational therapist, registered, for modern, 240 bed hospital in rural area. Experienced in treatment of physical disabilities. U.S. citizen. Salary range $392.00 to $491.00. With experience, starting salary second step $415.00), outstanding qualifications at third step ($439.00). Retirement system, including social security. Write to Tulare-Kings Counties Hospital Springville, California.

Assistant chief occupational therapist—Glenn Dale Hospital, 600-bed chronic diseases and tuberculosis hospital for the District of Columbia. Immediate opening; sal. range: $5,885 to $6,875; U.S. civil service requirements and benefits. Write: Superintendent and Medical Director, Glenn Dale Hospital, Glenn Dale, Md.

Experienced registered occupational therapist to operate occupational therapy department for 100 bed psychiatric unit in 800 bed hospital. Salary open. Contact John R. Mote, Administrative Assistant, Methodist Hospital, 1604 North Capitol Avenue, Indianapolis 7, Indiana.

Occupational therapists: 2 openings in comprehensive out-patient rehabilitation center. Excellent program and personnel policies. Chief occupational therapist minimum of 2 years experience. Starting salary $5700. Staff occupational therapist no experience necessary. Starting salary $4900. Contact L. Burke Crowder, Administrator, Community Rehabilitation Clinic, 614 Dartmouth Ave., SW, Canton 10, Ohio.

Occupational therapists—$3,993.00 to $6,996.00 depending on training and experience. (1) opening for 42 bed psychiatric ward; (1) vacancy for 42 bed rehabilitation floor (neurological and orthopedic disabilities, children and adults). Position of chief therapist is open. Contact Forbes Polliard, Coordinator, Curtis Hixon Rehabilitation Center, Tampa General Hospital, Tampa 6, Florida.

Openings now available for American registered occupational therapists in new facility serving industrially injured workers exclusively. Experienced therapists beginning salary $380.00 per month with annual increments. Paid vacations, sick leave, five-day week, both OASI and State retirement benefits. Apply: Miss Patsy J. Brittain, O.T.R., Supervising Occupational Therapist, Department of Labor and Industries Rehabilitation Center, 32nd Avenue South and Alaska Street, Seattle 8, Washington.

Challenging position open in a general hospital's new psychiatric division. "Therapeutic community" emphasis in the division's many levels of treatment such as out-patient, day-care, night-care units, homecare program, and residential treatment. Contact Mrs. Lottie Barth, O.T.R., Director of OT, Montefiore Hospital, 210th Street and Bainbridge, New York 67, New York.

Immediate openings for director of OT and staff positions in 3200-bed, intensive treatment, training and research psychiatric hospital with interdisciplinary treatment programs. State merit system, salary $4884-6540, periodic merit increments, 40-hour week, 11 paid holidays, 15 days paid vacation, sick leave, retirement plan, room and board available, student affiliations. Apply: Mrs. Antoinette Yerkes, O.T.R., Coordinator of Activity Therapies, St. Louis State Hospital, 5400 Arsenal St., St. Louis 39, Mo.

Immediate opening for staff OTR for newly constructed, progressive, comprehensive rehabilitation center. Attractive salary, liberal benefits, paid month's vacation, paid holidays. Apply to Bryce W. Nichols, Executive Director, Ohio Valley Goodwill Industries Rehabilitation Center, 10600 Springfield Pike, Cincinnati 15, Ohio.

Wanted: male or female OT's. Registered or registration eligible, for work in a large state psychiatric hospital. Excellent starting salary with many fringe benefits available. John W. Whitehouse, Personnel Director, South Carolina State Hospital, Columbia, S. C.

Director of occupational therapy—a wide variety of crippling and special health conditions are admitted for treatment under the supervision of an excellent medical staff. The hospital is accredited by Joint Commission on Accreditation of Hospitals. Good personnel policies include 4 weeks vacation each year. AOTA minimum salary exceeded depending upon qualifications. Apply to Gene Clark, Administrator Junior League Home for Crippled Children, Nashville 4, Tennessee.

Wanted: immediate opening for chief occupational therapist at 500 bed TB hospital having varied and interesting therapy program. Beautiful hospital grounds in rolling hills of western Pennsylvania near Pittsburgh and Lake Erie. Career civil service. Many fringe benefits. Contact Personnel Officer, VA Hospital, Butler, Pa.

Occupational therapist—part time, 16 hours weekly. Home care program. Salary plus mileage allowance. Write or telephone the personnel office, Beth Israel Hospital, 330 Brookline Avenue, Boston, Massachusetts.

Immediate position for staff OTR with two (2) years experience in progressive psychiatric hospital. Salary: $4773-$6090. Write Mrs. Haru Lemke, O.T.R., Director of Occupational Therapy, Allentown State Hospital, Allentown, Pennsylvania.

Position open for registered occupational therapist in a modern, recently expanded 200 bed general hospital located in a progressive midwestern community. Recently established department now serving eleven bed psychiatric unit. Occupational therapy program to be expanded to include general, medical and surgical patients. Salary open, commensurate with training and experience. Consultation and referrals available from local new rehabilitation center. Apply Box 100, American Journal of Occupational Therapy, 3514 N. Oakland Ave., Milwaukee 11, Wis.

Excellent opportunity for two registered therapists in large medical center. Rotation possible through physical disabilities, tuberculosis, and psychiatry. In and out patient services for all ages. Salary range $4128-$5160. Liberal benefits. Write J. B. Ahlschier, Administrator, Memorial Hospital, Medical College of Virginia, Richmond, Virginia.

Applications continually accepted for staff therapists in rehabilitation hospital treating children and adults. Addition completed recently includes complete new OT department. Current staff of five is being gradually increased to meet greater in and out patient capacity. Progressive personnel policies. Salary commensurate with experience and training. Location ideal for cultural interests and all sports. Further information and attractive brochure furnished on request. Apply to Administrator, Sunnyview Orthopaedic and Rehabilitation Center, Inc., 124 Rosa Road, Schenectady 8, New York.

Occupational therapist—for healthy, comfortable Phoenix, Arizona. Position in Maricopa County General Hospital. Pay range: $397 to $487 per month, including one daily meal. 40 hour work week. Apply: Maricopa County Personnel Department, 126 West Madison Street, Phoenix, Arizona.

Wanted: Immediate placement for qualified occupational therapist, male or female, for rehabilitation center which provides full rehabilitation services for in-patients and out-patients. Desirable working conditions and salary. Refer inquiries to: Administrator, Rehabilitation Center, Inc., 340 East Madison Street, Louisville 2, Kentucky.

Occupational therapist to handle well equipped department in modern rehabilitation center in southern city. Excellent working conditions, vacation and salary. Contact Medical Director, Clair Henderson Memorial Rehabilitation Center, 1206 East 66 Street, Savannah, Ga.

The Hartford Rehabilitation Center has an opening for an occupational therapist to work with male and female children and adults in a kinetic and functional program. The department comprises four therapists and program embraces treatment for out-patients with physical adjustment services for the epileptic, psychiatric and selected mentally retarded patients. The occupational therapy department is integrated with a constantly growing, comprehensive rehabilitation center, which includes intensive medical, social, psychological and vocational services. Clari Bare, OT Supervisor, 2 Holcomb Street, Hartford, Connecticut.

Immediate placement for registered qualified occupational therapist. Extensive expansion in rehabilitation program in state psychiatric hospital offers an opportunity for imagination and resourcefulness. Excellent experience available in treatment of children and adults. Only 30-minute drive from Richmond, Virginia. Opportunity for advancement. Hospital currently being modernized by remodeling and addition of new buildings. Mr. George T. Blaho, O.T.R., Director of Department. Salary $4128 to $5160. Contact Personnel Supervisor, Box 271, Petersburg, Virginia.

Wanted: occupational therapist to work half time with cerebral palsied children of preschool age. Supervision by experienced therapists in comprehensive treatment program. Good personnel practices in new modern equipped facility. Write: Administrative Director, Spastic Children's Clinic & Preschool, 1850 Boyer Avenue, Seattle 2, Washington.

Immediate openings: supervising therapist, O.T.R., one year experience. 147 bed tuberculosis unit. Student affiliation program. Salary $4355-5255. Staff therapist for newly established 98-bed PM & R unit. Salary $4130-$4890. Civil service, New York state retirement, social security, Blue Cross and Blue Shield, 11 paid holidays, generous vacation and sick leave, laundry. Low cost maintenance. Elizabeth M. Stanley, O.T.R., Director of Occupational Therapy, Mount View Hospital, Upper Mountain Road, Lockport, New York.

Supervising occupational therapist to head occupational therapy department in a 500 bed teaching hospital. Applicants should have had recent supervisory and administrative experience. Pleasant working conditions. University community. Contact Personnel Office, University of Virginia, 1416 W. Main Street, Charlottesville, Virginia.

Modern, well-equipped department in state hospital near Morristown, New Jersey, 30 miles from NYC. Staff positions available at $4,309 to $5,599. Opportunity for professional growth. Programs include clinics and prevocational areas. Lucille Boss, O.T.R., Director. Civil service benefits. Low cost maintenance usually available. Apply Richard E. Winans, Personnel Director, New Jersey State Hospital, Greystone Park, N.J.

Registered occupational therapists wanted: 2000 bed psychiatric veterans' hospital, Lyons, N. J. (near Plainfield, N.J.): Career civil service; liberal benefits; salary $4345 to $5335 and $5355 to $6345. Chance for advancement. Write: Personnel, VA Hospital, Lyons, New Jersey.

Position available immediately in 100 bed hospital for rheumatic fever and related diseases. Clinical training program, 5 day week, employee benefits, salary open. Pleasant surroundings in park area on shore of Lake Michigan. Apply K. B. Hudgens, Director of Occupational Therapy, La Rabida Jackson Park Sanitarium, East 65th at Lake Michigan, Chicago 49, Illinois.

Wanted immediately: occupational therapist, registered or eligible for registration, to direct a growing OT department in a 211 bed private hospital. Daily program consists of 4 hours in psychiatric ward and 4 hours on GM & S wards. Psychiatric ward features a well organized ward program on 13 bed ward. Case load affords maximum opportunity to establish good rapport and observe patients. Excellent interdepartmental relationships. GM & S wards provide unlimited opportunity for an industrious OT to expand growing physical disability rehabilitation ward program. Ultimate goal: shop program. Salary commensurate with experience. 40 hour week, 2 weeks paid vacation, 6 paid holidays. Benefits available: Blue Cross-Blue Shield, Workmen's Compensation coverage, sick leave, and retirement program. Building program begins fall of 1960 for new psychiatric unit and OT clinic. For further information contact Sister M. Paul, OSB, St. Alexius Hospital, Bismarck, North Dakota.

Wanted: staff therapist, new graduates eligible, for 2,000 bed NP hospital. Six well equipped clinics, certified assistant to help. Staff of 12. Salary: 6 months experience, $5355 to $6345, yearly raises. New graduates, $4345 usually promoted to $5355 one year. Uniform allowance, paid vacation and sick leave, health insurance plan, civil service benefits, career appointment. For more information write: Personnel Office, Veterans Administration Roanoke Hospital, Salem, Virginia.

Vacancies—occupational therapy supervisor—$4704.00 to $5880.00. Occupational therapist—$4128.00 to $5160.00. Must be registered. Excellent benefits and working conditions. Apply Personnel Director, Eastern State Hospital, Williamsburg, Virginia.

Georgia Warm Springs Foundation

GRADUATE COURSE

Physical Therapy and Occupational Therapy

In the Care of *Neuro-Muscular Disease*

This course is open to graduates of approved schools of physical and occupational therapy. Such graduates must be members of the American Physical Therapy Association and/or American Registry of Physical Therapists, or American Occupational Therapy Association.

Entrance dates: First Monday in January, April and October.

Course I—Emphasis on care of convalescent neuromuscular disease with intensive training in functional anatomy, muscle testing, muscle reeducation and use of supportive and assistive apparatus. This course is complete in itself.

Course II—Three months duration with course I prerequisite. Emphasis on care of severe chronic physical handicaps with intensive training in resumption of functional activity and use of adaptive apparatus.

In-Service Training Program—Fifteen months duration at salary of $225 per month plus full maintenance, increasing to $250 per month at the completion of nine months. This program includes training in course I and II.

Tuition: None. Maintenance is $100 per month. For scholarship to cover transportation and maintenance for course I and II, contact The National Foundation, 800 2nd Avenue, New York 17, N. Y. (Scholarships require two years of experience.)

For further information contact:

ROBERT L. BENNETT, M.D.
Medical Director

Georgia Warm Springs Foundation
WARM SPRINGS, GEORGIA

Have You Tried?

If your department has a kiln which does not reach a temperature high enough to allow swirling of flat copper pieces up to two and a half inches in diameter, Mr. John D. Miller, O.T.S., writes the following method may be used to obtain a higher temperature with such a kiln.

Bring the kiln up to the normal temperature for ordinary firing. Meanwhile, prepare your copper piece for swirling and when the kiln is hot enough, place inside. Remove the kiln cover and replace with an inverted aluminum pie plate about four to five inches in diameter and one and one-quarter inch deep. The pie plate does an excellent job of reflecting the heat and you should be able to swirl within one and one-half minutes.

As soon as the swirling is complete, remove the copper piece and replace the pie plate with the usual cover. The pie plate disintegrates if left on much longer than indicated above and should not be used more than a few times. It will turn a gray-silver just before the point of disintegration and should be discarded at this time.

The above method will retain enough heat to enable you to swirl an ashtray with slanting sides and up to two and a half inches in diameter.

The new Preston Catalog No. 1065, which the company describes as "the largest in our long service to the profession—208 pages, 1057 illustrations, and up-to-date price information on over 2500 products," is now available.

Among the features attributed to the new catalog are its functional organization, concise descriptions, and inclusion of new and additional famous lines. The organization of the Catalog enables all items in any category to be located instantly and compared with similar products to make buying decisions easier and more accurate. The descriptions are written with the objective of presenting a maximum of accurate, useful information in the fewest possible words.

Copies of the catalog are being mailed to all occupational therapists and occupational therapy departments on the Preston mailing list. A copy may be obtained by writing J. A. Preston Corporation, 175 Fifth Ave., New York 10, N. Y.

Running out of new ideas for knitting and crocheting? Write to the National Needlecraft Bureau, 430 Park Avenue, New York 22, N. Y., for new leaflets from Coats and Clark. The current release includes directions for a bedspread (S-381), doily (PC-9077), edging (PC-1514) and a cotton knit sweater (S-461). The edging is particularly attractive and has many uses. These are summertime suggestions for leisure hours that will also be an engrossing activity for many of your patients. Order photographs as well as sample direction leaflets and feel free to order as many as you want. They are free of charge to all occupational therapists.

A new catalog published by Nottingham Handcraft Company, Edwalton Hill, Melton Road, West Bridgford, Nottingham, England, has a new potters wheel and a new set of pottery tools. Also featured are the "Barpin" easels which can be easily stacked when not being used by children. Wet paintings can be left in position on the easels to dry even when stacked. Each easel can be used by two people. Write for the catalog, it is fascinating.

Do you have a nice new department or a newly redecorated one and are you getting your cupboards and equipment in shape? Then you want everything to be as neat and trim as possible. To save you time and energy in a small but time-consuming task, get a Dymo-Mite Labeler. It embosses labels on plastic and metal tapes in seconds that may be instantly applied. Imagine how trim your array of bins will look if each has a neatly embossed label.

This new labeler will even dress up an old department. It costs $34.95 and is well worth the price in the satisfaction it will give you. Patients will also enjoy helping you and some can even get good grasp activity punching the labels for you.

The Dymo-Mite Labeler is available from Rehabilitation Products, 2020 Ridge Avenue, Evanston, Illinois.

A new vinyl spray can be applied with a sprayer to renovate soiled upholstery and draperies. It can also be used on plastic, leather, natural and synthetic fibers. It does not change the texture but adds water repellency and retards soiling. It comes in a variety of colors. Called *"LASTI-COLOR,"* it is a new product of Taussig Paint Sales Co., Old York Road and Township Line, Jenkintown, Pa.

REPRINTS

Would you like a few reprints of articles but hesitate to send in your order because it is not large enough for a minimum order? Send the Journal your request for any number desired. It will be honored if enough orders are received to total 50 for an article. Orders should be placed before the 25th of the month of publication.

Speed progress in ADL

Patients with upper extremity disabilities gain self-reliance with these OT designed products. They speed the return of muscular function and promote and encourage individual self-care—ideal for hemiplegic, quadriplegic, post polio patients, and many others.

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TOMAC WHEEL CHAIR TABLE

With virtually unlimited adjustment possibilities, the Tomac Wheel Chair Table is ideal for work, eating or recreation. Unsurpassed for strength—it's sturdy enough to even support an electric typewriter. In an extreme raised position (10″), it's ideal for patients requiring almost complete arm support. Also tilts up to 35°.

Fits any make wheel chair easily and quickly by secure spring clamps. No space is lost between the double-tops for cumbersome raising devices. Extra-large top is 28″ x 28″ with 16″ x 8″ cut-outs.

No. 5215—Wheel Chair Table, ¾″ plywood top, each..... **$39.50**

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Helps prevent deformity and encourages activity. Excellent support for patient's arm to facilitate self-feeding, exercising and ADL.

Fits any tubular wheel chair with quickly installed bracket. Overhead support rod easily removed when sling is not in use. Sling assembly is adjustable to any position along overhead stainless steel rod. Comfortable leatherette slings adjust to any patient—adult or child.

No. 496-993-1—Arm Sling Suspension, each..... **$18.00***

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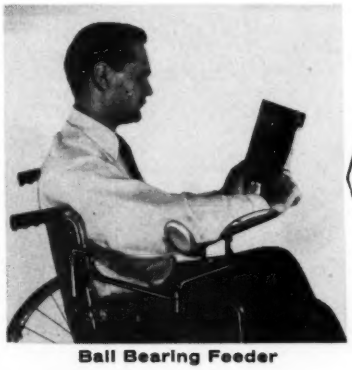
Arm Sling Suspension



Ball Bearing Feeder

BALL BEARING FEEDER

Assists the patients not only in self-feeding, but in many other necessary Activities of Daily Living. This feeder (Warm Springs' type) works on the principle of balance and gravity elimination by means of friction-free ball bearings. Patient can feed himself, write, read or paint with minimum effort.

All steel except for aluminum trough. Over-all dimensions when folded, 15½″ long, 3½″ high, 4½″ wide. Weighs 2 lbs. Specify for right or left hand.

No. 5220—Ball Bearing Feeder, adult..... **$25.00**

No. 5221—Same, but with Adjustable Chair Bracket for reclining wheel chairs..... **37.50**

No. 5222—Ball Bearing Feeder, child..... **25.00**

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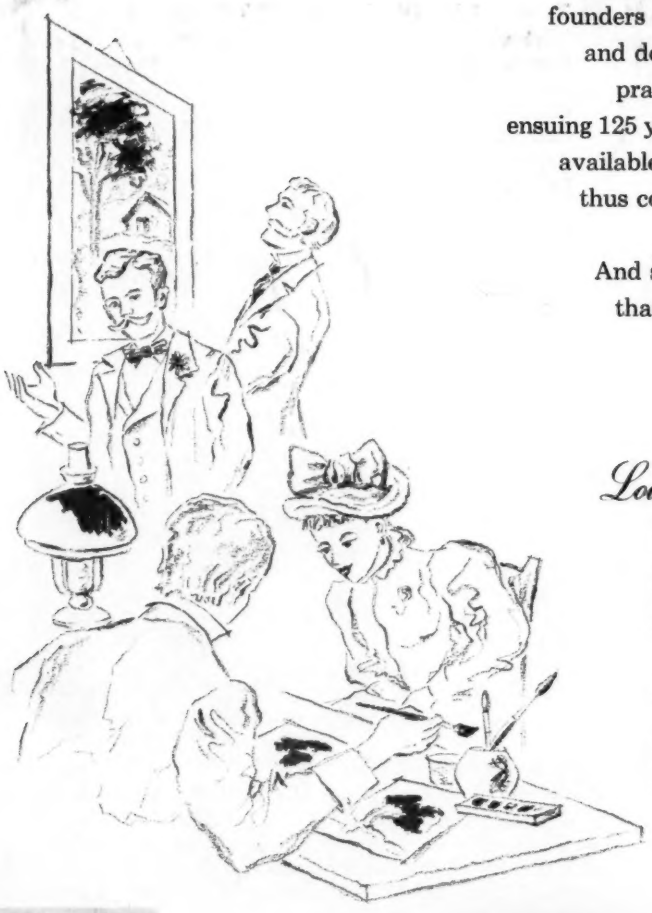

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